## CHAPTER 469

**H.P. 1187 - L.D. 1611**

**An Act To Provide Affordable Health Insurance to Small Businesses and Individuals and To Control Health Care Costs**

**Be it enacted by the People of the State of Maine as follows:**

## PART A

**Sec. A-1. 2 MRSA §6, sub-§1,** as amended by PL 1997, c. 643, Pt. Q, §1 and by PL 2001, c. 354, §3, is further amended to read:

**1. Range 91.** The salaries of the following state officials and employees are within salary range 91:

Commissioner of Transportation;

Commissioner of Conservation;

Commissioner of Administrative and Financial Services;

Commissioner of Education;

Commissioner of Environmental Protection;

Executive Director of Dirigo Health;

Commissioner of Human Services;

Commissioner of Behavioral and Developmental Services;

Commissioner of Public Safety;

Commissioner of Professional and Financial Regulation;

Commissioner of Labor;

Commissioner of Agriculture, Food and Rural Resources;

Commissioner of Inland Fisheries and Wildlife;

Commissioner of Marine Resources;

Commissioner of Corrections;

Commissioner of Economic and Community Development; and

Commissioner of Defense, Veterans and Emergency Management.

**Sec. A-2. 5 MRSA §934-B** is enacted to read:

**§934-B. Dirigo Health**

The position of executive director is a major policy-influencing position within Dirigo Health established pursuant to Title 24-A, chapter 87. Notwithstanding any other provision of law, this position and any successor position are subject to this chapter.

**Sec. A-3. 5 MRSA §12004-G, sub-§14-D** is enacted to read:

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| **14-D.** Health Care of Dirigo Health | Board of Directors and expenses | | $100 per diem | 24-A MRSA §6904 |

**Sec. A-4. 5 MRSA §12004-I, sub-§30-A** is enacted to read:

| | | | | |
|---|---|---|---|---|
| **30-A.** Health Care Forum Advisory Council | Maine Quality | | Expenses Only | 24-A MRSA §6952 |

**Sec. A-5. 22 MRSA §3174-G, sub-§1,** as amended by PL 2001, c. 450, Pt. A, §§1 and 2, is further amended to read:

**1. Delivery of services.** The department shall provide for the delivery of federally approved Medicaid services to the following persons:

A. A qualified woman during her pregnancy and up to 60 days following delivery when the woman's family income is equal to or below 200% of the nonfarm income official poverty line;

B. An infant under one year of age when the infant's family income is equal to or below 200% of the nonfarm income official poverty line;

C. A qualified elderly person when the person's family income is equal to or below 100% of the nonfarm income official poverty line and a qualified disabled person when that person's family income is equal to or below 125% of the nonfarm income official poverty line;

D. A child one year of age or older and under 19 years of age when the child's family income is equal to or below 200% of the nonfarm income official poverty line;

E. The parent or caretaker relative of a child described in paragraph B or D when the child's family income is equal to or below 200% of the nonfarm income official poverty line, subject to adjustment by the commissioner under this paragraph. Medicaid services provided under this paragraph must be provided within the limits of the program budget. Funds appropriated for services under this paragraph must include an annual inflationary adjustment equivalent to the rate of inflation in the Medicaid program. On a quarterly basis, the commissioner shall determine the fiscal status of program expenditures under this paragraph. If the commissioner determines that expenditures will exceed the funds available to provide Medicaid coverage pursuant to this paragraph, the commissioner must adjust the income eligibility limit for new applicants to the extent necessary to operate the program within the program budget. If, after an adjustment has occurred pursuant to this paragraph, expenditures fall below the program budget, the commissioner must raise the income eligibility limit to the extent necessary to provide services to as many eligible persons as possible within the fiscal constraints of the program budget, as long as the income limit does not exceed 200% of the nonfarm income official poverty line; and

F. A person 20 to 64 years of age who is not otherwise covered under paragraphs A to E when the person's family income is below or equal to 125% of the nonfarm income official poverty line, provided that the commissioner shall

adjust the maximum eligibility level in accordance with the requirements of the paragraph.

(2) If the commissioner reasonably anticipates the cost of the program to exceed the budget of the population described in this paragraph, the commissioner shall lower the maximum eligibility level to the extent necessary to provide coverage to as many persons as possible within the program budget.

(3) The commissioner shall give at least 30 days' notice of the proposed change in maximum eligibility level to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over health and human services matters.

For the purposes of this subsection, the "nonfarm income official poverty line" is that applicable to a family of the size involved, as defined by the federal Department of Health and Human Services and updated annually in the Federal Register under authority of 42 United States Code, Section 9902(2). For purposes of this subsection, "program budget" means the amounts available from both federal and state sources to provide federally approved Medicaid services.

**Sec. A-6. 22 MRSA §3174-DD** is enacted to read:

**§3174-DD. Dirigo health coverage**

The department may contract with one or more health insurance carriers to purchase Dirigo Health Insurance for MaineCare members who seek to enroll through their employers pursuant to Title 24-A, section 6910, subsection 4, paragraph B. A MaineCare member who enrolls in a Dirigo Health Insurance plan as a member of an employer group receives full MaineCare benefits through Dirigo Health Insurance. The benefits are delivered through the employer-based health plan, subject to nominal cost sharing as permitted by 42 United States Code, Section 1396o(2003) and additional coverage provided under contract by the department.

**Sec. A-7. 22 MRSA §3174-V, sub-§2,** as amended by PL 2003, c. 20, Part K, §11, is further amended to read:

**2. Contracted services.** When a federally qualified health center otherwise meeting the requirements of subsection 1 contracts with a

managed care plan or Dirigo Health Insurance for the provision of MaineCare services, the department shall reimburse that center the difference between the payment received by the center from the managed care plan or Dirigo Health Insurance and 100% of the reasonable cost, reduced by the total copayments for which members are responsible, incurred in providing services within the scope of service approved by the federal Health Resources and Services Administration or the commissioner. Any such managed care contract must provide payments for the services of a center that are not less than the level and amount of payment that the managed care plan or Dirigo Health Insurance would make for services provided by an entity not defined as a federally qualified health center.

**Sec. A-8. 24-A MRSA c. 87** is enacted to read:

## CHAPTER 87

## DIRIGO HEALTH

## SUBCHAPTER 1

## GENERAL PROVISIONS

### §6901. Short title

This chapter may be known and cited as "the Dirigo Health Act."

### §6902. Dirigo Health established; declaration of necessity

Dirigo Health is established as an independent executive agency to arrange for the provision of comprehensive, affordable health care coverage to eligible small employers, including the self-employed, their employees and dependents, and individuals on a voluntary basis. Dirigo Health is also responsible for monitoring and improving the quality of health care in this State. The exercise by Dirigo Health of the powers conferred by this chapter must be deemed and held to be the performance of essential governmental functions.

### §6903. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

**1. Board.** "Board" means the Board of Directors of Dirigo Health, as established in section 6904.

**2. Child.** "Child" means a natural child, stepchild, adopted child or child placed for adoption with a plan enrollee.

**3. Dependent.** "Dependent" means a spouse, an unmarried child under 19 years of age, a child who is a student under 23 years of age and is financially dependent upon a plan enrollee or a person of any age who is the child of a plan enrollee and is disabled and dependent upon that plan enrollee. "Dependent" may include a domestic partner consistent with sections 2741-A, 2832-A and 4249 and Title 24, section 2319-A.

**4. Dirigo Health Insurance.** "Dirigo Health Insurance" means the health insurance product established by Dirigo Health that is offered by a private health insurance carrier or carriers.

**5. Eligible business.** "Eligible business" means a business that employs at least 2 but not more than 50 eligible employees, the majority of whom are employed in the State, including a municipality that has 50 or fewer employees.

After one year of operation of Dirigo Health, the board may, by rule, define "eligible business" to include larger public or private employers.

**6. Eligible employee.** "Eligible employee" means an employee of an eligible business who works at least 20 hours per week for that eligible business. "Eligible employee" does not include an employee who works on a temporary or substitute basis or who does not work more than 26 weeks annually.

**7. Eligible individual.** "Eligible individual" means:

A. A self-employed individual who:

(1) Works and resides in the State; and

(2) Is organized as a sole proprietorship or in any other legally recognized manner in which a self-employed individual may organize, a substantial part of whose income derives from a trade or business through which the individual has attempted to earn taxable income;

B. An unemployed individual who resides in this State; or

C. An individual employed in an eligible business that does not offer health insurance.

**8. Employer.** "Employer" means the owner or responsible agent of a business authorized to sign contracts on behalf of the business.

**9. Executive director.** "Executive director" means the Executive Director of Dirigo Health.

**10. Health insurance carrier.** "Health insurance carrier" means:

A. An insurance company licensed in accordance with this Title to provide health insurance;

B. A health maintenance organization licensed pursuant to chapter 56;

C. A preferred provider arrangement administrator registered pursuant to chapter 32;

D. A nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24; or

E. An employee benefit excess insurance company licensed in accordance with this Title to provide property and casualty insurance that provides employee benefit excess insurance pursuant to section 707, subsection 1, paragraph C-1.

**11. Health plan in Medicaid.** "Health plan in Medicaid" means a health insurance carrier that meets the requirements of 42 Code of Federal Regulations, Part 438 (2002) and has a contract with the Department of Human Services to provide MaineCare-covered services to individuals enrolled in MaineCare.

**12. Participating employer.** "Participating employer" means an eligible business that contracts with Dirigo Health pursuant to section 6910, subsection 4, paragraph B and that has employees enrolled in Dirigo Health Insurance.

**13. Plan enrollee.** "Plan enrollee" means an eligible individual or eligible employee who enrolls in Dirigo Health Insurance through Dirigo Health. "Plan enrollee" includes an eligible employee who is eligible to enroll in MaineCare.

**14. Provider.** "Provider" means any person, organization, corporation or association that provides health care services and products and is authorized to provide those services and products under the laws of this State.

**15. Reinsurance or reinsurer.** "Reinsurance" and "reinsurer" have the same meanings as in section 741.

**16. Resident.** "Resident" has the same meaning as in section 2736-C, subsection 1, paragraph C-2.

**17. Subsidy.** "Subsidy" means a subsidy as described in section 6912.

**18. Third-party administrator.** "Third-party administrator" means any person who, on behalf of any person who establishes a health insurance plan covering residents, receives or collects charges, contributions or premiums for or settles claims on residents in connection with any type of health benefit provided in or as an alternative to insurance as defined by section 704, other than:

A. Any person listed in section 1901, subsection 1, paragraphs A to C and paragraphs E to O; or

B. Any person who provides those services in connection with a group health plan sponsored by an agricultural cooperative association located outside of this State that provides heath insurance coverage to members and employees of agricultural cooperative associations located within this State.

**19. Unemployed individual.** "Unemployed individual" means an individual who does not work more than 20 hours a week for any single employer.

## §6904. Board of Directors of Dirigo Health

Dirigo Health operates under the supervision of a Board of Directors established in accordance with this section.

**1. Appointments.** The board consists of 5 voting members and 3 ex officio, nonvoting members as follows.

A. The 5 voting members of the board must be appointed by the Governor, subject to review by the joint standing committee of the Legislature having jurisdiction over health insurance matters and confirmation by the Senate.

B. The 3 ex officio, nonvoting members of the board are:

(1) The Commissioner of Professional and Financial Regulation or the commissioner's designee;

(2) The director of the Governor's Office of Health Policy and Finance or the director of a successor agency; and

(3) The Commissioner of Administrative and Financial Services or the commissioner's designee.

**2. Qualifications of voting members.** Voting members of the board:

A. Must have knowledge of and experience in one or more of the following areas:

(1) Health care purchasing;

(2) Health insurance;

(3) MaineCare;

(4) Health policy and law;

(5) State management and budget; or

(6) Health care financing; and

B. Except as provided in this paragraph, may not be:

(1) A representative or employee of an insurance carrier authorized to do business in this State;

(2) A representative or employee of a health care provider operating in this State; or

(3) Affiliated with a health or health-related organization regulated by State Government.

A nonpracticing health care practitioner, retired or former health care administrator or retired or former employee of a health insurance carrier is not prohibited from being considered for board membership as long as that person is not currently affiliated with a health or health-related organization.

**3. Terms of office.** Voting members serve 3-year terms. Voting members may serve up to 2 consecutive terms. Of the initial appointees, one member serves an initial term of one year, 2 members serve initial terms of 2 years and 2 members serve initial terms of 3 years. The Governor shall fill any vacancy for an unexpired term in accordance with subsections 1 and 2. Members reaching the end of their terms may serve until replacements are named.

**4. Chair.** The Governor shall appoint one of the voting members as the chair of the board.

**5. Quorum.** Three voting members of the board constitute a quorum.

**6. Affirmative vote.** An affirmative vote of 3 members is required for any action taken by the board.

**7. Compensation.** A member of the board must be compensated according to the provisions of Title 5, section 12004-G, subsection 14-D; a member must receive compensation whenever that member fulfills any board duties in accordance with board bylaws.

**8. Meetings.** The board shall meet at least 4 times a year at regular intervals and may also meet at other times at the call of the chair or the executive director. All meetings of the board are public proceedings within the meaning of Title 1, chapter 13, subchapter 1.

## §6905. Limitation on liability

A member of the board or an employee of Dirigo Health is not subject to any personal liability for having acted within the course and scope of membership or employment to carry out any power or duty under this chapter. Dirigo Health shall indemnify any member of the board and any employee of Dirigo Health against expenses actually and necessarily incurred by that member or employee in connection with the defense of any action or proceeding in which that member or employee is made a party by reason of past or present authority with Dirigo Health.

## §6906. Prohibited interests of board members and employees

Board members and employees of Dirigo Health and their spouses and dependent children may not receive any direct personal benefit from the activities of Dirigo Health in assisting any private entity, except that they may participate in Dirigo Health Insurance on the same terms as others may under this chapter. This section does not prohibit corporations or other entities with which board members are associated by reason of ownership or employment from participating in activities of Dirigo Health or receiving services offered by Dirigo Health as long as the ownership or employment is made known to the board and, if applicable, the board members abstain from voting on matters relating to that participation.

## §6907. Confidential records

Except as provided in subsections 1 and 2, information obtained by Dirigo Health under this chapter is a public record within the meaning of Title 1, chapter 13, subchapter 1.

**1. Financial information.** Any personally identifiable financial information, supporting data or tax return of any person obtained by Dirigo Health under this chapter is confidential and not open to public inspection.

**2. Health information.** Health information obtained by Dirigo Health under this chapter that is covered by the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 110 Stat. 1936 or information covered by chapter 24 or Title 22, section 1711-C is confidential and not open to public inspection.

## §6908. Powers and duties of Dirigo Health

**1. Powers.** Subject to any limitations contained in this chapter or in any other law, Dirigo Health may:

A. Take any legal actions necessary or proper to recover or collect savings offset payments due Dirigo Health or that are necessary for the proper administration of Dirigo Health;

B. Make and alter bylaws, not inconsistent with this chapter or with the laws of this State, for the administration and regulation of the activities of Dirigo Health;

C. Have and exercise all powers necessary or convenient to effect the purposes for which Dirigo Health is organized or to further the activities in which Dirigo Health may lawfully be engaged, including the establishment of Dirigo Health Insurance;

D. Engage in legislative liaison activities, including gathering information regarding legislation, analyzing the effect of legislation, communicating with Legislators and attending and giving testimony at legislative sessions, public hearings or committee hearings;

E. Take any legal actions necessary to avoid the payment of improper claims against Dirigo Health or the coverage provided by or through Dirigo Health, to recover any amounts erroneously or improperly paid by Dirigo Health, to recover any amounts paid by Dirigo Health as a result of mistake of fact or law and to recover other amounts due Dirigo Health;

F. Enter into contracts with qualified 3rd parties both private and public for any service necessary to carry out the purposes of this chapter;

G. Conduct studies and analyses related to the provision of health care, health care costs and quality;

H. Establish and administer a revolving loan fund to assist health care practitioners and health care providers in the purchase of hardware and software necessary to implement the requirements for electronic submission of claims. Dirigo Health may solicit matching contributions to the fund from each health insurance carrier licensed to do business in this State;

I. Apply for and receive funds, grants or contracts from public and private sources;

J. Contract with the Maine Health Data Organization and other organizations with expertise in health care data, including a nonprofit health data processing entity in this State, to assist the Maine Quality Forum established in section 6951 in the performance of its responsibilities;

K. Provide staff support and other assistance to the Maine Quality Forum established in section 6951, including assigning a director and other staff as needed to conduct the work of the Maine Quality Forum; and

L. In accordance with the limitations and restrictions of this chapter, cause any of its powers or duties to be carried out by one or more organizations organized, created or operated under the laws of this State.

**2. Duties.** Dirigo Health shall:

A. Establish administrative and accounting procedures as recommended by the State Controller for the operation of Dirigo Health in accordance with Title 5;

B. Collect the savings offset payments provided in section 6913;

C. Determine the comprehensive services and benefits to be included in Dirigo Health Insurance and develop the specifications for Dirigo Health Insurance in accordance with the provisions in section 6910. Within 30 days of its determination of the benefit package to be offered through Dirigo Health Insurance, the board shall report on the benefit package, including the estimated premium and

applicable coinsurance, deductibles, copayments and out-of-pocket maximums, to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters and the joint standing committee of the Legislature having jurisdiction over health and human services matters;

D. Develop and implement a program to publicize the existence of Dirigo Health and Dirigo Health Insurance and the eligibility requirements and the enrollment procedures for Dirigo Health Insurance and to maintain public awareness of Dirigo Health and Dirigo Health Insurance;

E. Arrange the provision of Dirigo Health Insurance benefit coverage to eligible individuals and eligible employees through contracts with one or more qualified bidders;

F. Develop a high-risk pool for plan enrollees in Dirigo Health Insurance in accordance with the provisions of section 6971; and

G. Establish and operate the Maine Quality Forum in accordance with the provisions of section 6951.

**3. Budget.** The revenues and expenditures of Dirigo Health are subject to legislative approval in the biennial budget process. At the direction of the board, the executive director shall prepare the budget for the administration and operation of Dirigo Health in accordance with the provisions of law that apply to departments of State Government.

**4. Audit.** Dirigo Health must be audited annually by the State Auditor. The board may, in its discretion, arrange for an independent audit to be conducted. A copy of the audit must be provided to the State Controller, to the superintendent, to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters and to the joint standing committee of the Legislature having jurisdiction over health and human services matters.

**5. Rulemaking.** Dirigo Health may adopt rules as necessary for the proper administration and enforcement of this chapter, pursuant to the Maine Administrative Procedure Act. Unless otherwise specified, rules adopted pursuant to this chapter are

routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

**6. Annual report.** Beginning September 1, 2004, and annually thereafter, the board shall report on the impact of Dirigo Health on the small group and individual health insurance markets in this State and any reduction in the number of uninsured individuals in the State. The board shall also report on

membership in Dirigo Health, the administrative expenses of Dirigo Health, the extent of coverage, the effect on premiums, the number of covered lives, the number of Dirigo Health Insurance policies issued or renewed and Dirigo Health Insurance premiums earned and claims incurred by health insurance carriers offering Dirigo Health Insurance. The board shall submit the report to the Governor, the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, the joint standing committee of the Legislature having jurisdiction over health insurance and financial services matters and the joint standing committee of the Legislature having jurisdiction over health and human services matters.

**7. Technical assistance from other state agencies.** Other state agencies, including, but not limited to, the bureau, the Department of Human Services, Maine Revenue Services and the Maine Health Data Organization, shall provide technical assistance and expertise to Dirigo Health upon request.

**8. Legal counsel.** The Attorney General, when requested, shall furnish any legal assistance, counsel or advice Dirigo Health requires in the discharge of its duties.

**9. Coordination with federal, state and local health care systems.** Dirigo Health shall institute a system to coordinate the activities of Dirigo Health with the health care programs of the Federal Government and state and municipal governments.

**10. Initial staffing.** Upon request from the board, the Governor shall provide staffing assistance to Dirigo Health in the initial phases of its operation.

**11. Advisory committees.** Dirigo Health may appoint advisory committees to advise and assist Dirigo Health. Members of an advisory committee serve without compensation but may be reimbursed by Dirigo Health for necessary expenses while on official business of the advisory committee.

**§6909. Executive director**

**1. Appointed position.** The executive director is appointed by the board and serves at the pleasure of the board. The position of executive director is a major policy-influencing position as designated in Title 5, section 934-B.

**2. Duties of executive director.** The executive director shall:

A. Serve as the liaison between the board of directors and Dirigo Health and serve as secretary and treasurer to the board;

B. Manage Dirigo Health's programs and services, including the Maine Quality Forum established under section 6951;

C. Employ or contract on behalf of Dirigo Health for professional and nonprofessional personnel or service. Employees of Dirigo Health are subject to the Civil Service Law, except that the position of Director of the Maine Quality Forum is not subject to the Civil Service Law;

D. Approve all accounts for salaries, per diems, allowable expenses of Dirigo Health or of any employee or consultant and expenses incidental to the operation of Dirigo Health; and

E. Perform other duties prescribed by the board to carry out the functions of this chapter.

## §6910. Dirigo Health Insurance

**1. Dirigo Health Insurance.** Dirigo Health shall arrange for the provision of health benefits coverage through Dirigo Health Insurance not later than October 1, 2004. Dirigo Health Insurance must comply with all relevant requirements of this Title. Dirigo Health Insurance may be offered by health insurance carriers that apply to the board and meet qualifications described in this section and any additional qualifications set by the board.

**2. Legislative approval of nonprofit health care plan or expansion of public plan.** If health insurance carriers do not apply to offer and deliver Dirigo Health Insurance, the board may have Dirigo Health provide access to health insurance by proposing the establishment of a nonprofit health care plan organized under Title 13-B and authorized pursuant to Title 24, chapter 19 or by proposing the expansion of an existing public plan. If the board proposes the establishment of a nonprofit health care plan or the expansion of an existing public plan, the board shall submit its proposal, including, but not limited to, a funding mechanism to capitalize a nonprofit health care plan and

any recommended legislation to the joint standing committee of the Legislature having jurisdiction over health insurance matters. Dirigo Health may not provide access to health insurance by establishing a nonprofit health care plan or through an existing public plan without specific legislative approval.

**3. Carrier participation requirements.** To qualify as a carrier of Dirigo Health Insurance, a health insurance carrier must:

A. Provide the comprehensive health services and benefits as determined by the board, including a standard benefit package that meets the requirements for mandated coverage for specific health services, specific diseases and for certain providers of health services under Title 24 and this Title and any supplemental benefits the board wishes to make available; and

B. Ensure that:

(1) Providers contracting with a carrier contracted to provide coverage to plan enrollees do not charge plan enrollees or 3rd parties for covered health care services in excess of the amount allowed by the carrier the provider has contracted with, except for applicable copayments, deductibles or coinsurance or as provided in section 4204, subsection 6;

(2) Providers contracting with a carrier contracted to provide coverage to plan enrollees do not refuse to provide services to a plan enrollee on the basis of health status, medical condition, previous insurance status, race, color, creed, age, national origin, citizenship status, gender, sexual orientation, disability or marital status. This subparagraph may not be construed to require a provider to furnish medical services that are not within the scope of that provider's license; and

(3) Providers contracting with a carrier contracted to provide coverage to plan enrollees are reimbursed at the negotiated reimbursement rates between the carrier and its provider network.Health insurance carriers that s eek to qualify to provide
Dirigo Health Insurance must also qualify as health plans in Medicaid.

**4. Contracting authority.** Dirigo Health has contracting authority and powers to administer Dirigo Health Insurance as set out in this subsection.

A. Dirigo Health may contract with health insurance carriers licensed to sell health insurance in this State or other private or public third-party administrators to provide Dirigo Health Insurance. In addition:

(1) Dirigo Health shall issue requests for proposals from health insurance carriers;

(2) Dirigo Health may include quality improvement, disease prevention, disease management and cost-containment provisions in the contracts with participating health insurance carriers or may arrange for the provision of such services through contracts with other entities;

(3) Dirigo Health shall require participating health insurance carriers to offer a benefit plan identical to Dirigo Health Insurance, for which no Dirigo Health subsidies are available, in the general small group market;

(4) Dirigo Health shall make payments to participating health insurance carriers under a Dirigo Health Insurance contract to provide Dirigo Health Insurance benefits to plan enrollees not enrolled in MaineCare;

(5) Dirigo Health may set allowable rates for administration and underwriting gains for Dirigo Health Insurance;

(6) Dirigo Health may administer continuation benefits for eligible individuals from employers with 20 or more employees who have purchased health insurance coverage through Dirigo Health for the duration of their eligibility periods for continuation benefits pursuant to the federal Consolidated Omnibus Budget Reconciliation Act, Public Law 99-272, Title X, Private Health Insurance Coverage, Sections 10001 to 10003; and

(7) Dirigo Health may administer or contract to administer the United States Internal Revenue Code of 1986, Section 125 plans for employers and employees participating in Dirigo Health, including medical expense reimbursement accounts and dependent care reimbursement accounts.

B. Dirigo Health shall contract with eligible businesses seeking assistance from Dirigo Health in arranging for health benefits coverage by Dirigo Health Insurance for their employees and dependents as set out in this paragraph.

(1) Dirigo Health may establish contract and other reporting forms and procedures necessary for the efficient administration of contracts.

(2) Dirigo Health shall collect payments from participating employers and plan enrollees to cover the cost of:

(a) Dirigo Health Insurance for enrolled employees and dependents in contribution amounts determined by the board;

(b) Dirigo Health's quality assurance, disease prevention, disease management and cost-containment programs;

(c) Dirigo Health's administrative services; and

(d) Other health promotion costs.

(3) Dirigo Health shall establish the minimum required contribution levels, not to exceed 60%, to be paid by employers toward the aggregate payment in subparagraph (2) and establish an equivalent minimum amount to be paid by employers or plan enrollees and their dependents who are enrolled in MaineCare. The minimum required contribution level to be paid by employers must be prorated for employees that work less than the number of hours of a full-time equivalent employee as determined by the employer. Dirigo Health may establish a separate minimum contribution level to be paid by employers toward coverage for dependents of the employers' enrolled employees.

(4) Dirigo Health shall require participating employers to certify that at least 75% of their employees that work 30 hours or more per week and who do not have other creditable coverage are enrolled in Dirigo Health Insurance and that the employer group otherwise meets the minimum participation requirements specified by section 2808-B, subsection 4, paragraph A.

(5) Dirigo Health shall reduce the payment amounts for plan enrollees eligible for a subsidy under section 6912 accordingly. Dirigo Health shall return any payments made by plan enrollees also enrolled in MaineCare to those enrollees.

(6) Dirigo Health shall require participating employers to pass on any subsidy in section 6912 to the plan enrollee qualifying for the subsidy, up to the amount of payments made by the plan enrollee.

(7) Dirigo Health may establish other criteria for participation.

(8) Dirigo Health may limit the number of participating employers.

C. Dirigo Health may permit eligible individuals to purchase Dirigo Health Insurance for themselves and their dependents as set out in this paragraph.

(1) Dirigo Health may establish contract and other reporting forms and procedures necessary for the efficient administration of contracts.

(2) Dirigo Health may collect payments from eligible individuals participating in Dirigo Health Insurance to cover the cost of:

(a) Enrollment in Dirigo Health Insurance for eligible individuals and dependents;

(b) Dirigo Health's quality assurance, disease prevention, disease management and cost-containment programs;

(c) Dirigo Health's administrative services; and

(d) Other health promotion costs.

(3) Dirigo Health shall reduce the payment amounts for individuals eligible for a subsidy under section 6912 accordingly.

(4) Dirigo Health may require that eligible individuals certify that all their dependents are enrolled in Dirigo Health Insurance or are covered by another creditable plan.

(5) Dirigo Health may require an eligible individual who is currently employed by an eligible employer that does not offer health insurance to certify that the current employer did not provide access to an employer-sponsored benefits plan in the 12-month period immediately preceding the eligible individual's application.

(6) Dirigo Health may limit the number of plan enrollees.

(7) Dirigo Health may establish other criteria for participation.

**5. Enrollment in Dirigo Health Insurance.** Dirigo Health shall perform, at a minimum, the following functions to facilitate enrollment in Dirigo Health Insurance.

A. Dirigo Health shall publicize the availability of Dirigo Health Insurance to businesses, self-employed individuals and others eligible to enroll in Dirigo Health Insurance.

B. Dirigo Health shall screen all eligible individuals and employees for eligibility for subsidies under section 6912 and eligibility for MaineCare. To facilitate the screening and referral process, Dirigo Health shall provide a single application form for Dirigo Health and MaineCare. The application materials must inform applicants of subsidies available through Dirigo Health and of the additional coverage available through MaineCare. It must allow an applicant to choose on the application form to apply or not to apply for MaineCare or for a subsidy. It must allow an applicant to provide household financial information necessary to determine eligibility for MaineCare or a subsidy. Except when the applicant has declined to apply for MaineCare or a subsidy, an application must be treated as an application for Dirigo Health, for a subsidy and for MaineCare. MaineCare must make the final determination of eligibility for MaineCare.

C. Except as provided in this paragraph, the effective date of coverage for a new enrollee in Dirigo Health Insurance is the first day of the month following receipt of the fully completed application for that enrollee by the carrier contracting with Dirigo Health or the first day of the next month if the fully completed application is received by the carrier within 10 calendar days of the end of the month. If a new enrollee in Dirigo Health Insurance had prior coverage through an individual or small group policy, coverage under Dirigo Health Insurance must take effect the day following termination of that enrollee's prior coverage.

**6. Quality improvement, disease management and cost containment.** Dirigo Health shall promote quality improvement, disease prevention, disease management and cost-containment programs as part of its administration of Dirigo Health Insurance.

## §6911. Coordination with MaineCare

The Department of Human Services is the state agency responsible for the financing and administration of MaineCare. It s hall pay for MaineCare benefits for MaineCare-eligible individuals, including those enrolled in health plans in MaineCare that are providing coverage under Dirigo Health Insurance.

## §6912. Subsidies

Dirigo Health may establish sliding-scale subsidies for the purchase of Dirigo Health Insurance paid by individuals or employees whose income is under 300% of the federal poverty level and who are not eligible for MaineCare. Dirigo Health may also establish sliding-scale subsidies for the purchase of employer-sponsored health coverage paid by employees of businesses with more than 50 employees, whose income is under 300% of the federal poverty level and who are not eligible for MaineCare.

**1. Administration.** Dirigo Health shall, by rule, establish procedures to administer this section.

**2. Individuals eligible for subsidy.** Individuals eligible for a subsidy must:

A. Have an income under 300% of the federal poverty level, be a resident of the State, be ineligible for MaineCare coverage and be enrolled in Dirigo Health Insurance; or

B. Be enrolled in a health plan of an employer with more than 50 employees. The health plan must meet any criteria established by Dirigo Health. The individual must meet other eligibility criteria established by Dirigo Health.

**3. Limitation of subsidies.** Dirigo Health shall limit the availability of subsidies to reflect limitations of available funds.

**4. Limitation on amount subsidized.** Dirigo Health may limit the amount subsidized of the payment made by individual plan enrollees under section 6910, subsection 4, paragraph C to 40% of the payment to more closely parallel the subsidy received by employees. In no case may the subsidy granted to eligible individuals in accordance with subsection 2, paragraph A exceed the maximum subsidy level available to other eligible individuals.

**5. Notification of subsidy.** Dirigo Health shall notify applicants and their employers in writing of their eligibility and approved level of subsidy.

**6. Report.** Within 30 days after any subsidies are established pursuant to this section, the board shall report on the amount of the subsidies, the funding required for the subsidies and the estimated number of Dirigo Health enrollees eligible for the subsidies and submit the report to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters and the joint standing committee of the Legislature having jurisdiction over health and human services matters.

## §6913. Savings offset payments against health insurance carriers, employee benefit excess insurance carriers and third-party administrators

**1. Determination of cost savings.** After an opportunity for a hearing conducted pursuant to Title 5, chapter 375, subchapter 4, the board shall determine annually not later than April the aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.

**2. Savings offset payments.** For the purpose of providing the funds necessary to provide subsidies pursuant to section 6912 and support the Maine Quality Forum established pursuant to subchapter 2, the board shall establish a savings offset amount to be paid by health insurance carriers, employee benefit excess insurance carriers and third-party administrators, not including carriers and third-party administrators with respect to accidental injury, specified disease, hospital indemnity, dental, vision, disability, income, long-term care, Medicare supplement or other limited benefit health insurance, annually at a rate that may not exceed savings resulting from decreasing rates of growth in the State's health care spending and in bad debt and charity care costs. Payment of the savings offset amount must begin 12 months after Dirigo Health begins providing health insurance coverage. The savings offset payment amount, as determined by the board, is the determining factor for inclusion of savings offset payments in premiums through rate setting review by the bureau. Savings offset payments must be made quarterly and are due not less than 30 days after written notice to the health insurance carriers, employee benefit excess insurance carriers

and third-party administrators and must accrue interest at 12% per annum on or after the due date.

**3. Maximum savings offset payments on health insurance carriers and employee benefit excess insurance carriers.** Each health insurance carrier and employee benefit excess insurance carrier must pay a savings offset in an amount not to exceed 4.0% of annual health insurance premiums and employee benefit excess insurance premiums on policies issued pursuant to the laws of this State that insure residents of this State. The savings offset payment may not exceed savings resulting from decreasing rates of growth in the State's health care spending and bad debt and charity care costs. The savings offset payment applies to premiums paid on or after July 1, 2005. Savings offset payments must reflect aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State, as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004, as determined by the board consistent with subsection 1. A health insurance carrier and employee benefit excess insurance carrier may not be required to pay a savings offset payment on policies or contracts insuring federal employees.

**4. Determination of savings offset payments.** The board shall make reasonable efforts to ensure that premium revenue, or claims plus any administrative expenses and fees with respect to third-party administrators, is counted only once with respect to any savings offset payment. For that purpose, the board shall require each health insurance carrier to include in its premium revenue gross of reinsurance ceded. The board shall allow a health insurance carrier to exclude from its gross premium revenue reinsurance premiums that have been counted by the primary insurer for the purpose of determining its savings offset payment under this subsection. The board shall allow each employee benefit excess insurance carrier to exclude from its gross premium revenue the amount of claims that have been counted by a third-party administrator for the purpose of determining its savings offset payment under this subsection. The board may verify each health insurance carrier, employee benefit excess insurance carrier and third-party administrator's savings offset payment based on annual statements and other reports determined to be necessary by the board.

**5. Failure to pay savings offset payments.** The superintendent may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any health insurance carrier or employee benefit excess insurance carrier or the license of any third-party administrator

to operate in this State that fails to pay a savings offset payment. In addition, the superintendent may assess civil penalties against any health insurance carrier, employee benefit excess insurance carrier or third-party administrator that fails to pay a savings offset payment or may take any other enforcement action authorized under section 12-A to collect any unpaid savings offset payments.

**6. Savings offset payments through reductions in growth in State's health care spending and bad debt and charity care.** On an annual basis no later than April of each year, the board shall prospectively determine the savings offset to be applied during each 12-month period. To make its determination, the board shall use the criteria and reports described in subsections 7 and 8. Annual offset payments must be reconciled to determine whether unused payments may be returned to health insurance carriers, employee benefit excess insurance carriers and third-party administrators according to a formula developed by the board. Savings offset payments must be used solely to fund the subsidies authorized by section 6912 and to support the Maine Quality Forum established in subchapter 2 and may not exceed savings from reductions in growth of the State's health care spending and bad debt and charity care.

**7. Demonstration of recovery of savings offset payments through reduction in rate of growth in State's health spending and bad debt and charity care.** In accordance with the requirements of this subsection, every health insurance carrier and health care provider shall demonstrate that best efforts have been made to ensure that a carrier has recovered savings offset payments made pursuant to this section through negotiated reimbursement rates that reflect health care providers' reductions or stabilization in the cost of bad debt and charity care as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.

A. A health insurance carrier shall use best efforts to ensure health insurance premiums reflect any such recovery of savings offset payments as those savings offset payments are reflected through incurred claims experience in accordance with subsection 9.

B. During any negotiation with a health insurance carrier relating to a health care provider's reimbursement agreement with that carrier, a health care provider shall provide data relating to any reduction or avoidance of bad debt and charity care costs to health care providers in this State, as a result of the operation of Dirigo Health and as a

result of any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.

**8. Reports.** The following reports are required in accordance with this subsection.

A. On a quarterly basis beginning with the first quarter after Dirigo Health Insurance begins offering coverage, the board shall collect and report on the following:

(1) The total enrollment in Dirigo Health Insurance, including the number of enrollees previously underinsured or uninsured, the number of enrollees previously insured, the number of individual enrollees and the number of enrollees enrolled through small employers;

(2) The total number of enrollees covered in health plans through large employers and self-insured employers;

(3) The number of employers, both small employers and large employers, who have ceased offering health insurance or contributing to the cost of health insurance for employees or who have begun offering coverage on a self-insured basis;

(4) The number of employers, both small employers and large employers, who have begun to offer health insurance or contribute to the cost of health insurance premiums for their employees;

(5) The number of new participating employers in Dirigo Health Insurance;

(6) The number of employers ceasing to offer coverage through Dirigo Health Insurance;

(7) The duration of employers participating in Dirigo Health Insurance; and

(8) A comparison of actual enrollees in Dirigo Health Insurance to the projected enrollees.

B. The board shall establish the total health care spending in the State for the base year of 2002 and shall annually determine, in collaboration with the superintendent, appropriate actuarially supported trend factors that reflect savings consistent with subsection 1 and compare rates of spending growth to the base year of 2002. The board shall collect on an annual basis, in consultation with the

superintendent, the total cost to the State's health care providers of bad debt and charity care beginning with the base year of 2002. This information may be compiled through mechanisms, including, but not limited to, standard reporting or statistically accurate surveys of providers and practitioners. The board shall utilize existing data on file with state agencies or other organizations to minimize duplication. The comparisons to the base year must be reported beginning March 1, 2004 and annually thereafter.

C. Health insurance carriers and health care providers shall report annually, beginning March 1, 2005 and thereafter, information regarding the experience of a prior 12-month period on the efforts undertaken by the carrier and provider to recover savings offset payments, as reflected in reimbursement rates, through a reduction or stabilization in bad debt and charity care costs as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004. The board shall determine the appropriate format for the report and utilize existing data on file with state agencies or other organizations to minimize duplication. The report must be submitted to the board. Using the information submitted by carriers and providers, the board shall submit a summary of that information by October 1, 2005 and annually thereafter.

D. The quarterly reports required to be submitted by the board pursuant to paragraph A and the annual reports required to be submitted by the board pursuant to paragraphs B and C must be submitted to the superintendent, to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters, and to the joint standing committee of the Legislature having jurisdiction over health and human services matters.

**9. Demonstration of offset.** As provided in sections 2736-C, 2808-B and 2839-B, the claims experience used to determine any filed premiums or rating formula must reasonably reflect, in accordance with accepted actuarial standards, known changes and offsets in payments by the carrier to health care providers in this State, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004 as determined by the board consistent with subsection 1.

**§6914. Intragovernmental transfer**

Starting July 1, 2004, Dirigo Health shall transfer funds, as necessary, to a special dedicated, nonlapsing revenue account administered by the agency of State Government that administers MaineCare for the purpose of providing a state match for federal Medicaid dollars. Dirigo Health shall annually set the amount of contribution. The transfer may not include money collected as a savings payment offset pursuant to section 6913.

## §6915. Dirigo Health Fund

The Dirigo Health Fund is created as a dedicated fund for the deposit of any funds advanced for initial operating expenses, payments made by employers and individuals, any savings offset payments made pursuant to section 6913 and any funds received from any public or private source. The fund may not lapse, but must be carried forward to carry out the purposes of this chapter.

# SUBCHAPTER 2

# HEALTH CARE QUALITY

## §6951. Maine Quality Forum

The Maine Quality Forum, referred to in this subchapter as "the forum," is established within Dirigo Health. The forum is governed by the board with advice from the Maine Quality Forum Advisory Council pursuant to section 6952. The forum must be funded, at least in part, through the savings offset payments made pursuant to section 6913. Except as provided in section 6907, subsection 2, information obtained by the forum is a public record as provided by Title 1, chapter 13, subchapter 1. The forum shall perform the following duties.

**1. Research dissemination.** The forum shall collect and disseminate research regarding health care quality, evidence-based medicine and patient safety to promote best practices.

**2. Quality and performance measures.** The forum shall adopt a set of measures to evaluate and compare health care quality and provider performance. The measures must be adopted with guidance from the advisory council pursuant to section 6952. The quality measures adopted by the forum must be the basis for the rules for the collection of quality data adopted by the Maine Health Data Organization pursuant to Title 22, section 8708-A.

**3. Data coordination.** The forum shall coordinate the collection of health care quality data in the State. The forum shall work with the Maine Health Data Organization and other

entities that collect health care data to minimize duplication and to minimize the burden on providers of data.

**4. Reporting.** The forum shall work collaboratively with the Maine Health Data Organization, health care providers, health insurance carriers and others to report in useable formats comparative health care quality information to consumers, purchasers, providers, insurers and policy makers. The forum shall produce annual quality reports in conjunction with the Maine Health Data Organization pursuant to Title 22, section 8712.

**5. Consumer education.** The forum shall conduct education campaigns to help health care consumers make informed decisions and engage in healthy lifestyles.

**6. Technology assessment.** The forum shall conduct technology assessment reviews to guide the use and distribution of new technologies in this State. The forum shall make recommendations to the certificate of need program under Title 22, chapter 103-A.

**7. Electronic data.** The forum shall encourage the adoption of electronic technology and assist health care practitioners to implement electronic systems for medical records and submission of claims. The assistance may include, but is not limited to, practitioner education, identification or establishment of low-interest financing options for hardware and software and system implementation support.

**8. State health plan.** The forum shall make recommendations for inclusion in the State Health Plan described under Title 2, chapter 5, including recommendations based on the technology assessment reviews under subsection 6.

**9. Annual report.** The forum shall make an annual report to the public. The forum shall provide the report to the joint standing committees of the Legislature having jurisdiction over appropriations and financial affairs, health and human services matters and insurance and financial services matters.

## §6952. Maine Quality Forum Advisory Council

The Maine Quality Forum Advisory Council, referred to in this subchapter as "the advisory council," is a 17-member body established by Title 5, section 12004-I, subsection 30-A, to advise the forum. Except as provided in section 6907, subsection 2, information obtained by the advisory council is a public record as provided by Title 1, chapter 13, subchapter 1.

**1. Appointment; composition.** The Governor shall appoint the following members with the approval of the joint standing committee of the Legislature having jurisdiction over health and human services matters:

A. Seven members representing providers, including 3 physicians, one registered nurse, one representative of hospitals, one mental health provider and one health care practitioner who is not a physician. The 3 physician members must represent allopathic physicians, osteopathic physicians, primary care physicians and specialist physicians;

B. Four members representing consumers, including one employee who receives health care through a commercially insured product, one representative of organized labor, one representative of a consumer health advocacy group and one representative of the uninsured or MaineCare recipients;

C. Four members representing employers, including one member of the State Employee Health Commission, one representative of a private employer with more than 1,000 full-time equivalent employees, one representative of a private employer with 50 to 1,000 full-time employees and one representative of a private employer with fewer than 50 employees;

D. One representative of a private health plan; and

E. One representative of the MaineCare program.

Prior to making appointments to the advisory council, the Governor shall seek nominations from the public and from a statewide allopathic association, a statewide osteopathic association, a statewide hospital association, a statewide nurses association, a statewide health purchasing collaborative, a statewide health management coalition, organized labor, a statewide organization representing consumers advocating for affordable health care, a statewide association representing consumers of mental health services, a national association of retired persons, a statewide citizen action organization, a statewide organization advocating equal justice, a statewide organization representing local chambers of commerce, a statewide organization representing businesses for social responsibility, a statewide small business alliance, a national federation of independent businesses, a statewide association of health plans and other entities as appropriate.

**2. Terms.** Members of the advisory council serve 5-year terms except for initial appointments. Initial appointments must include 5 members appointed to 3-year terms, 6 members appointed

to 4-year terms and 6 members appointed to 5-year terms. A member may not serve more than 2 consecutive terms.

**3. Compensation.** Members of the advisory council are eligible for compensation according to the provisions of Title 5, chapter 379.

**4. Quorum.** A quorum is a majority of the members of the advisory council.

**5. Chair and officers.** The advisory council shall annually choose one of its members to serve as chair for a one-year term. The advisory council may select other officers and designate their duties.

**6. Meetings.** The advisory council shall meet at least 4 times a year at regular intervals and may meet at other times at the call of the chair or the executive director of Dirigo Health. Meetings of the council are public proceedings as provided by Title 1, chapter 13, subchapter 1.

**7. Duties.** The advisory council shall:

A. Convene a group of health care providers to provide input and advice to the council. The council shall invite members broadly representing health care practitioners as defined in Title 24, section 2502, subsection 1-A, health care providers as defined in Title 24, section 2502, subsection 2, federally qualified health centers and pharmacists. Members serve as volunteers and without compensation or reimbursement for expenses;

B. Provide expertise in health care quality to assist the board;

C. Advise and support the forum by:

(1) Establishing and monitoring, with Dirigo Health, an annual work plan for the forum;

(2) Providing guidance in the adoption of quality and performance measures;

(3) Serving as a liaison between the provider group established in paragraph A and the forum;

(4) Conducting public hearings and meetings; and

(5) Reviewing consumer education materials developed by the forum;

D. Make recommendations regarding quality assurance and quality improvement priorities for inclusion in the State Health Plan described in Title 2, chapter 5; and

E. Serve as a liaison between the forum and other organizations working in the field of health care quality.

## SUBCHAPTER 3

## DIRIGO HEALTH HIGH-RISK POOL

### §6971. Dirigo Health High-risk Pool

Dirigo Health shall establish the Dirigo Health High-risk Pool, referred to in this section as "the high-risk pool" for plan enrollees in accordance with this section.

**1. Eligible enrollees for high-risk pool.** A plan enrollee must be included in the high-risk pool if:

A. The total cost of health care services for the enrollee exceeds $100,000 in any 12-month period; or

B. The enrollee has been diagnosed with one or more of the following conditions: acquired immune deficiency syndrome (HIV/AIDS), angina pectoris, cirrhosis of the liver, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia, Hodgkin's disease, Huntington's chorea, juvenile diabetes, leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia gravis, myotonia, heart disease requiring open-heart surgery, Parkinson's disease, polycystic kidney disease, psychotic disorders, quadriplegia, stroke, syringomyelia, and Wilson's disease.

**2. Disease management.** Dirigo Health shall develop appropriate disease management protocols, develop procedures for implementing those protocols and determine the manner in which disease management must be provided to plan enrollees in the high-risk pool. Dirigo Health may include disease management in its contract with participating carriers for Dirigo Health Insurance pursuant to section 6910, contract separately with another entity for disease management services or provide disease management services directly through Dirigo Health.

**3. Report.** Dirigo Health shall submit a report, no later than January 1, 2006, outlining the disease management protocols, procedures and delivery mechanisms used to provide services to plan enrollees. The report must also include the number of plan enrollees in the high-risk pool, the types of diagnoses managed within the high-risk pool, the claims experience within the high-risk pool and the number and type of claims exceeding $100,000 for enrollees in the high-risk pool and for all enrollees in Dirigo Health Insurance. The report must be submitted to the joint standing committee of the Legislature having jurisdiction over health insurance matters. The committee may make recommendations on the operation of the high-risk pool and may report out legislation to the Second Regular Session of the 122nd Legislature relating to the high-risk pool.

**4. Establishment of statewide high-risk pool.** After 3 years of operation, but no later than October 1, 2007, Dirigo Health shall evaluate the impact of Dirigo Health on average premium rates in this State and on the rate of uninsured individuals in this State and compare the trends in those rates to the trends in the average premium rates and average rates of uninsured individuals for the 31 states that have established a statewide high-risk pool as of July 1, 2003. The board shall submit the evaluation of the impact of Dirigo Health in this State in comparison to states with high-risk pools to the joint standing committee of the Legislature having jurisdiction over health insurance matters by January 1, 2008. If the trend in average premium rates in this State and rate of uninsured individuals exceed the trend for the average among the 31 states with high-risk pools, the board shall submit legislation on January 1, 2008 to the Second Regular Session of the 123rd Legislature that proposes to establish a statewide high-risk pool in this State consistent with the characteristics of high-risk pools operating in other states.

**Sec. A-9. Monthly report.** The Department of Human Services shall provide a monthly report of enrollment and expenditures for the noncategorical adults enrolled in the MaineCare program under the Maine Revised Statutes, Title 22, section 3174-G, subsection 1, paragraph F. The report must include the number of members, expenses and projections for expenses in the state fiscal year for members enrolled under the expansion of income eligibility from 100% of the nonfarm income official poverty line to 125% of the nonfarm income official poverty line.

**Sec. A-10. Determination of savings offset payments for third-party administrators.** The Governor's Office of Health Policy and Finance and the Board of Directors of Dirigo Health, established pursuant to the Maine Revised Statutes, Title 24,

chapter 87, shall develop a methodology to determine an appropriate savings offset payment to be paid by third-party administrators as required by Title 24-A, section 6913, subsection 2. In developing the methodology, the Governor's office and the board shall consult with and reach consensus among self-insured employers, multiple-employer welfare arrangements and third-party administrators. The methodology must take into account both the similarities and the differences that exist between self-insured plans, multiple-employer welfare arrangements and health insurance. No later than February 1, 2004, the board shall report on the methodology, including recommended legislation to implement the savings offset payments, to the Joint Standing Committee on Insurance and Financial Services. The Joint Standing Committee on Insurance and Financial Services may report out legislation to the Second Regular Session of the 121st Legislature to implement the savings offset payments.

**Sec. A-11. Effective date.** That section of this Part that amends the Maine Revised Statutes, Title 22, section 3174-G, subsection 1 takes effect on the date that coverage is first provided to eligible employees and eligible individuals under Dirigo Health Insurance as established in Title 24-A, section 6910.

## PART B

**Sec. B-1. 2 MRSA c. 5** is enacted to read:

### CHAPTER 5

### STATE HEALTH PLANNING

**§101. Duties of Governor**

**1. Governor.** The Governor or the Governor's designee shall:

A. Develop and issue the biennial State Health Plan, referred to in this chapter as "the plan," pursuant to section 103. The first plan must be issued by May 2004;

B. Make an annual report to the public assessing the progress toward meeting goals of the plan and provide any needed updates to the plan;

C. Issue an annual statewide health expenditure budget report that must serve as the basis for establishing priorities within the plan; and

D. Establish a limit, called the capital investment fund, for each year of the plan pursuant to section 102.

The Governor shall provide the reports specified in paragraphs B and C to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, the joint standing committee of the Legislature having jurisdiction over health and human services matters and the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters.

**§102. Capital investment fund**

**1. Purpose.** The capital investment fund is a limit for resources allocated annually under the certificate of need program described in Title 22, chapter 103-A.

**2. Process; criteria.** The process for determining the capital investment fund amount must be set forth in rules and may include the formation of an ad hoc expert panel to advise the Governor. The process must include the division of the total capital investment fund amount into nonhospital and hospital components, must establish large and small capital investment fund amounts within each component and must be based on 3rd-year capital and operating expenses of projects under the certificate of need program. The process must take into account the following:

A. The plan;

B. The opportunity for improved operational efficiencies in the State's health care system;

C. The average age of the infrastructure of the State's health care system; and

D. Technological developments and the dissemination of technology in health care.

**3. Nonhospital capital expenditures.** For the first 3 years of the plan, the nonhospital component of the capital investment fund must be at least 12.5% of the total.

This subsection is repealed July 1, 2007.

**§103. State Health Plan**

**1. Purpose.** The plan issued pursuant to section 101, subsection 1, paragraph A must set forth a comprehensive, coordinated approach to the development of health care facilities and resources in the State based on statewide cost, quality and access goals and strategies to ensure access to affordable health

care, maintain a rational system of health care and promote the development of the health care workforce.

**2. Input.** In developing the plan, the Governor shall, at a minimum, seek input from the Advisory Council on Health Systems Development, pursuant to section 104; the Maine Quality Forum and the Maine Quality Forum Advisory Council, pursuant to Title 24-A, chapter 87, subchapter 2; a statewide health performance council; and other agencies and organizations.

**3. Requirements.** The plan must:

A. Assess health care cost, quality and access in the State;

B. Develop benchmarks to measure cost, quality and access goals and report on progress toward meeting those goals;

C. Establish and set annual priorities among health care cost, quality and access goals;

D. Prioritize the capital investment needs of the health care system in the State within the capital investment fund, established under section 102;

E. Outline strategies to:

(1) Promote health systems change;

(2) Address the factors influencing health care cost increases; and

(3) Address the major threats to public health and safety in the State, including, but not limited to, lung disease, diabetes, cancer and heart disease; and

F. Provide recommendations to help purchasers and providers make decisions that improve public health and build an affordable, high-quality health care system.

**4. Uses of plan.** The plan must be used in determining the capital investment fund amount pursuant to section 102 and must guide the issuance of certificates of need by the State and the health care lending decisions of the Maine Health and Higher Education Facilities Authority. A certificate of need or public financing that affects health care costs may not be provided unless it meets goals and budgets explicitly outlined in the plan.

**§104. Advisory Council on Health Systems Development**

**1. Appointment; composition.** The Advisory Council on Health Systems Development, established in Title 5, section 12004-I, subsection 31-A and referred to in this section as "the council," consists of the following 11 members appointed by the Governor with approval of the joint standing committee of the Legislature having jurisdiction over health and human services matters:

A. Two individuals with expertise in health care delivery;

B. One individual with expertise in long-term care;

C. One individual with expertise in mental health;

D. One individual with expertise in public health care financing;

E. One individual with expertise in private health care financing;

F. One individual with expertise in health care quality;

G. One individual with expertise in public health;

H. Two representatives of consumers; and

I. One representative of the Department of Human Services, Bureau of Health program that works collaboratively with other organizations to improve the health of the citizens of this State.

Prior to making appointments to the council, the Governor shall seek nominations from the public, from statewide associations representing hospitals, physicians and consumers and from individuals and organizations with expertise in health care delivery systems, health care financing, health care quality and public health.

**2. Term.** Members of the council serve 5-year terms except for initial appointees. Initial appointees must include 3 members appointed to 3-year terms, 4 members appointed to 4-year terms and 4 members appointed to 5-year terms. A member may not serve more than 2 consecutive terms.

**3. Compensation.** Members of the council are entitled to compensation according to the provisions of Title 5, chapter 379.

**4. Quorum.** A quorum is a majority of the members of the council.

**5. Chair.** The council shall annually choose one of its members to serve as chair for a one-year term.

**6. Meetings.** The council shall meet at least 4 times a year at regular intervals and may meet at other times at the call of the chair or the Governor. Meetings of the council are public proceedings as provided by Title 1, chapter 13, subchapter 1.

**7. Duties.** The council shall advise the Governor in developing the plan by:

A. Collecting and coordinating data on health systems development in this State;

B. Synthesizing relevant research; and

C. Conducting at least 2 public hearings on the plan and the capital investment fund each biennium.

**8. Staff support.** The Governor's office shall provide staff support to the council. The Department of Human Services, Bureau of Health, the Maine Health Data Organization and other agencies of State Government as necessary and appropriate shall provide additional staff support or assistance to the council.

**9. Data.** The council shall solicit data and information from both the public and private sectors to help inform the council's work.

A. The following organizations shall forward data that documents key public health needs, organized by region of the State, to the council annually:

(1) The Department of Human Services, Bureau of Health;

(2) The Maine Center for Public Health Practice established pursuant to Title 22, section 3-D; and

(3) A statewide public health association.

B. Public purchasers using state or municipal funds to purchase health care services or health insurance shall, beginning January 1, 2004, submit to the council a consolidated public purchasers expenditure report outlining all funds expended in the most recently completed state fiscal year for hospital inpatient and outpatient care, physician services, prescription drugs, long-term care, mental health and other services and administration, organized by agency.

C. The council shall encourage private purchasers established under Title 13, Title 13-B and Title 13-C to develop and submit to the council a health expenditure report similar to that described in paragraph B.

**§105. Rulemaking**

The Governor shall adopt rules for the implementation of this chapter. Rules adopted pursuant to this chapter are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A.

**Sec. B-2. 5 MRSA §12004-I, sub-§31-A** is enacted to read:

| | | | |
|---|---|---|---|
| **31-A.** Health Care | Advisory Council on Health Systems Development | Expenses Only | 2 MRSA §104 |

**Sec. B-3. 22 MRSA §253,** as amended by PL 2001, c. 354, §3, is repealed.

**Sec. B-4. 22 MRSA §1709,** as enacted by PL 1965, c. 231, §3, is repealed.

**PART C**

**Sec. C-1. 5 MRSA §12004-I, sub-§38,** as amended by PL 1997, c. 689, Pt. A, §1 and affected by Pt. C, §2, is repealed.

**Sec. C-2. 22 MRSA §328, sub-§3-A** is enacted to read:

**3-A. Capital investment fund.** "Capital investment fund" means that fund established by the Governor pursuant to Title 2, section 101, subsection 1, paragraph D.

**Sec. C-3. 22 MRSA §328, sub-§8,** as enacted by PL 2001, c. 664, §2, is amended to read:

**8. Health care facility.** "Health care facility" means a hospital, psychiatric hospital, nursing facility, kidney disease treatment center including

a freestanding hemodialysis facility, rehabilitation facility, ambulatory surgical facility, independent radiological service center, independent cardiac catheterization center or cancer treatment center. "Health care facility" does not include the office of a private health care practitioner, as defined in Title 24, section 2502, subsection 1-A, whether in individual or group practice. In an ambulatory surgical facility that functions also as the office of a health care practitioner, the following portions of the ambulatory surgical facility are considered to be a health care facility:

A. Operating rooms;

B. Recovery rooms;

C. Waiting areas for ambulatory surgical facility patients; and

D. Any other space used primarily to support the activities of the ambulatory surgical facility.

**Sec. C-4. 22 MRSA §328, sub-§16,** as enacted by PL 2001, c. 664, §2, is amended to read:

**16. Major medical equipment.** "Major medical equipment" means a single unit of medical equipment or a single system of components with related functions used to provide medical and other health services that costs $1,200,000 or more. "Major medical equipment" does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services if the clinical laboratory is independent of a physician's office and a hospital and has been determined to meet the requirements of the United States Social Security Act, Title XVIII, Section 1861(s), paragraphs 10 and 11. In determining whether medical equipment costs more than the threshold provided in this subsection, the cost of studies, surveys, designs, plans, working drawings, specifications and other activities essential to acquiring the equipment must be included. If the equipment is acquired for less than fair market value, the term "cost" includes the fair market value. Beginning September 30, 2004 and annually thereafter, the threshold amount for review must be updated by the commissioner to reflect the change in the Consumer Price Index, medical index.

**Sec. C-5. 22 MRSA §328, sub-§17-A** is enacted to read:

**17-A. New health service.** "New health service" means:

**1. Capital expenditure.** The obligation of any capital expenditures by or on behalf of a health care facility of $110,000 or more that is associated with the addition of a health service that was not offered on a regular basis by or on behalf of the health care facility within the 12-month period prior to the time the services would be offered;

**2. Addition of health service.** The addition of a health service that is to be offered by or on behalf of a health care facility that was not offered on a regular basis by or on behalf of the health care facility within the 12-month period prior to the time the services would be offered and that, for the 3rd fiscal year of operation, including a partial first year following addition of that service, is projected to entail incremental annual operating costs directly attributable to the addition of that health service of at least $400,000; or

**3. Addition of health care practitioner.** The addition in the private office of a health care practitioner, as defined in Title 24, section 2502, subsection 1-A, of new technology that costs $1,200,000 or more. The department shall consult with the Maine Quality Forum Advisory Council established pursuant to Title 24-A, section 6952, prior to determining whether a project qualifies as a new technology in the office of a private practitioner. Beginning September 30, 2004 and annually thereafter, the threshold amount for review must be updated by the commissioner to reflect the change in the Consumer Price Index medical index. With regard to the private office of a health care practitioner, "new health service" does not include the location of a new practitioner in a geographic area.

"New health service" does not include a health care facility that extends a current service within the defined primary service area of the health care facility by purchasing within a 12-month time period new equipment costing in the aggregate less than the threshold provided in section 328, subsection 16;

**Sec. C-6. 22 MRSA §328, sub-§27** is enacted to read:

**27. State Health Plan.** "State Health Plan" means the plan developed in accordance with Title 2, chapter 5.

**Sec. C-7. 22 MRSA §329, sub-§§2 to 4,** as enacted by PL 2001, c. 664, §2, are amended to read:

**2. Acquisitions of major medical equipment.** Acquisitions of major medical equipment. The use of major medical equipment on a

temporary basis in the case of a natural disaster, major accident or equipment failure and the use of replacement equipment do not require a certificate of need. Beginning September 30, 2004 and annually thereafter, the threshold amount for review must be updated by the commissioner to reflect the change in the Consumer Price Index medical index;

**3. Capital expenditures.** Except as provided in subsection 6, the obligation by or on behalf of a health care facility of any capital expenditure of $2,400,000 or more. Capital expenditures in the case of a natural disaster, major accident or equipment failure for replacement equipment or for parking lots and garages, information and communications systems and physician office space do not require a certificate of need. Beginning September 30, 2004 and annually thereafter, the threshold amount for review must be updated by the commissioner to reflect the change in the Consumer Price Index medical index;

**4. New health service.** The offering or development of any new health service;

**Sec. C-8. 22 MRSA §335, sub-§1,** as enacted by PL 2001, c. 664, §2, is repealed and the following enacted in its place:

**1. Basis for decision.** Based solely on a review of the record maintained under subsection 6, the commissioner shall approve an application for a certificate of need if the commissioner determines that the project:

A. Meets the conditions set forth in subsection 7;

B. Is consistent with the State Health Plan;

C. Ensures high-quality outcomes and does not negatively affect the quality of care delivered by existing service providers;

D. Does not result in inappropriate increases in service utilization, according to the principles of evidence-based medicine adopted by the Maine Quality Forum, as established in Title 24-A, section 6951; and

E. Can be funded within the capital investment fund.

**Sec. C-9. 22 MRSA §335, sub-§1-A** is enacted to read:

**1-A. Review cycle.** The commissioner shall review applications periodically on a competitive basis.

**Sec. C-10. 22 MRSA §335, sub-§5,** as enacted by PL 2001, c. 664, §2, is amended to read:

**5. Record.** The record created by the department in the course of its review of an application must contain the following:

A. The application and all other materials submitted by the applicant for the purpose of making those documents part of the record;

B. All information generated by or for the department in the course of gathering material to assist the commissioner in determining whether the conditions for granting an application for a certificate of need have or have not been met. This information may include, without limitation, the report of consultants, including reports by panels of experts assembled by the department to advise it on the application, memoranda of meetings or conversations with any person interested in commenting on the application, letters, memoranda and documents from other interested agencies of State Government and memoranda describing officially noticed facts;

C. Stenographic or electronic recordings of any public hearing held by the commissioner or the staff of the department at the direction of the commissioner regarding the application;

D. Stenographic or electronic recording of any public informational meeting held by the department pursuant to section 337, subsection 5;

E. Any documents submitted by any person for the purpose of making those documents part of the record regarding any application for a certificate of need or for the purpose of influencing the outcome of any analyses or decisions regarding an application for certificate of need, except documents that have been submitted anonymously. Such source-identified documents automatically become part of the record upon receipt by the department;

F. Preliminary and final analyses of the record prepared by the staff; and

G. Written assessments by the Director of the Bureau of Health and the Superintendent of Insurance assessing the impact of the application on the health care system or cost of health insurance in the State.

**Sec. C-11. 22 MRSA §335, sub-§7, ¶¶C and D,** as enacted by PL 2001, c. 664, §2, are amended to read:

C. There is a public need for the proposed services as demonstrated by certain factors, including, but not limited to:

(1) Whether, and the extent to which, the project will substantially address specific health problems as measured by health needs in the area to be served by the project;

(2) Whether the project will have a positive impact on the health status indicators of the population to be served;

(3) Whether the services affected by the project will be accessible to all residents of the area proposed to be served; and

(4) Whether the project will provide demonstrable improvements in quality and outcome measures applicable to the services proposed in the project;

D. The proposed services are consistent with the orderly and economic development of health facilities and health resources for the State as demonstrated by:

(1) The impact of the project on total health care expenditures after taking into account, to the extent practical, both the costs and benefits of the project and the competing demands in the local service area and statewide for available resources for health care;

(2) The availability of state funds to cover any increase in state costs associated with utilization of the project's services; and

(3) The likelihood that more effective, more accessible or less costly alternative technologies or methods of service delivery may become available<u>; and</u>

**Sec. C-12. 22 MRSA §335, sub-§7, ¶E** is enacted to read:

<u>E. The project meets the criteria set forth in subsection 1.</u>

**Sec. C-13. 22 MRSA §338, sub-§1, ¶¶A and B,** as enacted by PL 2001, c. 664, §2, are amended to read:

A. New medical technologies and the impact of those technologies on the health care delivery system in the State;

B. Unmet need for health care services in the State; and

**Sec. C-14. 22 MRSA §338, sub-§1, ¶C** is enacted to read:

C. The quality of health care.

**Sec. C-15. 22 MRSA §1718** is enacted to read:

**§1718. Consumer information**

Each hospital or ambulatory surgical center licensed under chapter 405 shall maintain a price list of the most common inpatient services and outpatient procedures provided by the licensee.

A. For inpatient services, the price list must include a per diem bed charge and an average charge for all ancillary charges for the 15 most common nonemergent services involving inpatient stays. If the per diem bed charge includes all ancillary charges for a procedure, no further information is required.

B. For outpatient nonemergent procedures for which an individual would not incur a bed charge, the price list must include average charges for the 20 most common surgical and diagnostic procedures, excluding laboratory services.

C. For emergency services, the price list must include average charges for facility and physician services according to the level of emergency services provided by the hospital and based on the time and intensity of services provided.

The hospital or ambulatory surgical center licensed under chapter 405 shall post in a conspicuous place a statement about the availability of the price list as required by this section. Posting of the price list is not required.

The hospital or ambulatory surgical center licensed under chapter 405 shall provide its price list upon request of a consumer.

The price list may include a statement that actual charges may vary depending on individual need and other factors.

**Sec. C-16. 22 MRSA §2061, sub-§2,** as amended by PL 1993, c. 390, §24, is further amended to read:

**2. Review.** Each project for a health care facility has been reviewed and approved to the extent required by the agency of the State that serves as the Designated Planning Agency of the State or by the Department of Human Services in accordance with the provisions of the Maine Certificate of Need Act of 2002, as amended, and is consistent with the cost containment provisions for health care and health coverage of the State Health Plan adopted pursuant to Title 2, section 101, paragraph A;

**Sec. C-17. 22 MRSA §8702, sub-§4,** as amended by PL 2001, c. 596, Pt. B, §21 and affected by §25, is further amended to read:

**4. Health care facility.** "Health care facility" means a public or private, proprietary or not-for-profit entity or institution providing health services, including, but not limited to, a radiological facility licensed under chapter 160, a health care facility licensed under chapter 405 or certified under chapter 405-D, an independent radiological service center, a federally qualified health center, rural health clinic or rehabilitation agency certified or otherwise approved by the Division of Licensing and Certification within the Department of Human Services, a home health care provider licensed under chapter 419, a residential care facility licensed under chapter 1664, a hospice provider licensed under chapter 1681, a retail store drug outlet licensed under Title 32, chapter 117, a state institution as defined under Title 34-B, chapter 1 and a mental health facility licensed under Title 34-B, chapter 1.

**Sec. C-18. 22 MRSA §8702, sub-§4-A** is enacted to read:

**4-A. Health care practitioner.** "Health care practitioner" has the meaning provided in Title 24, section 2502, subsection 1-A.

**Sec. C-19. 22 MRSA §8702, sub-§8,** as enacted by PL 1995, c. 653, Pt. A, §2 and affected by §7, is amended to read:

**8. Payor.** "Payor" means a 3rd-party payor or 3rd-party administrator.

**Sec. C-20. 22 MRSA §8702, sub-§9-A** is enacted to read:

**9-A. Quality data.** "Quality data" means information on health care quality required to be submitted pursuant to section 8708-A.

**Sec. C-21. 22 MRSA §8702, sub-§11,** as amended by PL 2001, c. 677, §2, is further amended to read:

**11. Third-party payor.** "Third-party payor" means a health insurer, nonprofit hospital, medical services organization or managed care organization licensed in the State or the plan established in chapter 854. "Third-party payor" does not include carriers licensed to issue limited benefit health policies or accident, specified disease, vision, disability, long-term care or nursing home care policies.

**Sec. C-22. 22 MRSA §8703, sub-§1,** as amended by PL 2001, c. 457, §4, is further amended to read:

**1. Objective.** The purposes of the organization are to create and maintain a useful, objective, reliable and comprehensive health information database that is used to improve the health of Maine citizens and to issue reports, as provided in section 8712. This database must be publicly accessible while protecting patient confidentiality and respecting providers of care. The organization shall collect, process , analyze and report clinical , financial, quality and restructuring data as defined in this chapter.

**Sec. C-23. 22 MRSA §8704, sub-§1, ¶A,** as amended by PL 2001, c. 457, §7, is further amended to read:

A. The board shall develop and implement policies and procedures for the collection, processing, storage and analysis of clinical, financial, quality and restructuring data in accordance with this subsection for the following purposes:

(1) To use, build and improve upon and coordinate existing data sources and measurement efforts through the integration of data systems and standardization of concepts;

(2) To coordinate the development of a linked public and private sector information system;

(3) To emphasize data that is useful, relevant and not duplicative of existing data;

(4) To minimize the burden on those providing data; and

(5) To preserve the reliability, accuracy and integrity of collected data while ensuring that the data is available in the public domain.

**Sec. C-24. 22 MRSA §8704, sub-§1, ¶C,** as enacted by PL 1995, c. 653, Pt. A, §2 and affected by §7, is amended to read:

C. The organization may modify the uniform reporting systems for clinical, financial, quality and restructuring data to allow for differences in the scope or type of services and in financial structure among health care facilities, providers or payors subject to this chapter.

**Sec. C-25. 22 MRSA §8704, sub-§7,** as amended by PL 2001, c. 457, §9, is further amended to read:

**7. Annual report.** The board shall prepare and submit an annual report on the operation of the organization and the Maine Health Data Processing Center as authorized in Title 10, section 681, including any activity contracted for by the organization, and on health care trends to the Governor and the joint standing committee of the Legislature having jurisdiction over health and human services matters no later than February 1st of each year. The report must include an annual accounting of all revenue received and expenditures incurred in the previous year and all revenue and expenditures planned for the next year. The report must include a list of persons or entities that requested data from the organization in the preceding year with a brief summary of the stated purpose of the request.

**Sec. C-26. 22 MRSA §8704, sub-§10,** as amended by PL 2001, c. 457, §10, is repealed.

**Sec. C-27. 22 MRSA §8707, sub-§2,** as enacted by PL 1995, c. 653, Pt. A, §2 and affected by §7, is amended to read:

**2. Notice and comment period.** The rules must establish criteria for determining whether information is confidential clinical data, confidential financial data or privileged medical information and adopt procedures to give affected health care providers and payors notice and opportunity to comment in response to requests for information that may be considered confidential or privileged.

**Sec. C-28. 22 MRSA §8708-A** is enacted to read:

**§8708-A. Quality data**

The board shall adopt rules regarding the collection of quality data. The board shall work with the Maine Quality Forum and the Maine Quality Forum Advisory Council established in Title 24-A, chapter 87, subchapter 2 to develop the rules. The rules must be based on the quality measures adopted by the Maine Quality Forum pursuant to Title 24-A, section 6951, subsection 2.

The rules must specify the content, form, medium and frequency of quality data to be submitted to the organization. In the collection of quality data, the organization must minimize duplication of effort, minimize the burden on those required to provide data and focus on data that may be retrieved in electronic format from within a health care practitioner's office or health care facility. As specified by the rules, health care practitioners and health care facilities shall submit quality data to the organization. Rules adopted pursuant to this section are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A.

**Sec. C-29. 22 MRSA §8712** is enacted to read:

**§8712. Reports**

The organization shall produce clearly labeled and easy-to-understand reports as follows. Unless otherwise specified, the organization shall distribute the reports on a publicly accessible site on the Internet or via mail or e-mail, through the creation of a list of interested parties. The organization shall publish a notice of the availability of these reports at least once per year in the 3 daily newspapers of the greatest general circulation published in the State. The organization shall make reports available to members of the public upon request.

**1. Quality.** At a minimum, the organization, in conjunction with the Maine Quality Forum, established in Title 24-A, section 6951, shall develop and produce annual quality reports.

**2. Price.** At a minimum, the organization, with advice from the Maine Health Data Processing Center as authorized in Title 10, section 681, shall develop and produce annual reports on prices charged for the 15 most common services provided by health care facilities and health care practitioners, excluding emergency services. For health care facilities, the reports must include, but are not limited to, the average price charged per service per facility and total number of services per facility.

**3. Comparison report.** At a minimum, the organization shall develop and produce an annual report that compares the 15 most common diagnosis-related groups and the 15 most common outpatient procedures for all hospitals in the State and the 15 most common procedures for nonhospital health care facilities in the State to similar data for medical care rendered in other states, when such data are available.

**4. Physician services.** The organization shall provide an annual report of the 10 services and procedures most often provided by osteopathic and allopathic physicians in the private office setting in this State. The organization shall distribute this report to all physician practices in the State. The first report must be produced by July 1, 2004.

**Sec. C-30. 24 MRSA §2987** is enacted to read:

**§2987. Consumer information**

A health care practitioner shall notify patients in writing of the health care practitioner's charges for health care services commonly offered by the practitioner. Upon request of a patient, a health care practitioner shall assist the patient in determining the actual payment from a 3rd-party payor for a health care service commonly offered by the practitioner. A patient may file a complaint with the appropriate licensing board regarding a health care practitioner who fails to provide the consumer information required by this section.

## PART D

**Sec. D-1. 24 MRSA §2332-E,** as amended by PL 2003, c. 218, §1, is further amended to read:

**§2332-E. Standardized claim forms**

All nonprofit hospital or medical service organizations and nonprofit health care plans providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed health care practitioner must accept the current standardized claim form for professional services approved by the Federal Government and submitted electronically. All nonprofit hospital or medical service organizations and nonprofit health care plans providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form for professional or facility services, as applicable, approved by the Federal Government and submitted electronically. A nonprofit hospital or medical service organization or nonprofit health care plan may not be required to accept a claim submitted on a form other than the applicable form specified in this section and may not be required to accept a claim that is not submitted electronically, except from a health care practitioner who is exempt pursuant to section 2985.

**Sec. D-2. 24 MRSA §2985,** as enacted by PL 1993, c. 477, Pt. D, §7 and affected by Pt. F, §1, is repealed and the following enacted in its place:

**§2985. Billing for health care services**

A health care practitioner, as defined in section 2502, subsection 1-A, who directly bills for health care services must use the current standardized claim form for professional services approved by the Federal Government and, after October 16, 2003, must submit claims in electronic data format to a carrier, as defined in Title 24-A, section 4301-A, subsection 3, that accepts claims in an electronic format. A health care practitioner or group of health care practitioners with fewer than 10 full-time-equivalent health care practitioners and other employees is exempt from the requirement to submit claims in electronic data format until October 16, 2005. Beginning October 16, 2005, a health care practitioner or group of health care practitioners with fewer than 10 full-time-equivalent health care practitioners and other employees may apply to the Superintendent of Insurance for a continued exemption from the requirement to submit claims in electronic data format based upon hardship. The Superintendent of Insurance shall adopt rules relating to the process for a hardship exemption and the standard for determining whether a practitioner has demonstrated hardship. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

**Sec. D-3. 24-A MRSA §1912,** as amended by PL 2003, c. 218, §2, is further amended to read:

**§1912. Standardized claim forms**

All administrators who administer claims and who provide payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed health care practitioner must accept the current standardized claim form for professional services approved by the Federal Government and submitted electronically. All administrators who administer claims and who provide payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form for professional or facility services, as applicable, approved by the Federal Government and submitted electronically. An administrator may not be required to accept a claim submitted on a form other than the applicable form specified in this section and may not be required to accept a claim that is not submitted electronically, except from a health care practitioner who is exempt pursuant to Title 24, section 2985.

**Sec. D-4. 24-A MRSA §2436, sub-§2-A,** as amended by PL 2003, c. 218, §3, is further amended to read:

**2-A.** Except as provided in this subsection, for purposes of this section, an "undisputed claim" means a timely claim for payment of covered health care expenses under a policy or certificate providing health care coverage that is submitted to an insurer on the insurer's standard claim form using the most current published procedural codes with all the required fields completed with correct and complete information in accordance with the insurer's published claims filing requirements. After October 16, 2003 and until October 16, 2005, for a provider with 10 or more full-time-equivalent employees, an "undisputed claim" means a timely claim for payment of covered health care expenses under a policy or certificate providing health care coverage that is submitted to an insurer in the insurer's standard electronic data format using the most current published procedural codes with all the required fields completed with correct and complete information in accordance with the insurer's published claims filing requirements. This subsection applies only to a policy or certificate of a health plan as defined in section 4301-A, subsection 7.

**Sec. D-5. 24-A MRSA §2680,** as amended by PL 2003, c. 218, §5, is further amended to read:

**§2680. Standardized claim form**

Administrators providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed health care practitioner or licensed hospital shall accept the current standardized claim form for professional or facility services, as applicable, approved by the Federal Government and submitted electronically. An administrator may not be required to accept a claim submitted on a form other than the applicable form specified in this section and may not be required to accept a claim that is not submitted electronically, except from a health care practitioner who is exempt pursuant to Title 24, section 2985.

**Sec. D-6. 24-A MRSA §2753,** as amended by PL 2003, c. 218, §6, is further amended to read:

**§2753. Standardized claim forms**

All insurers providing individual medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a health care practitioner must accept the current standardized claim

form for professional services approved by the Federal Government and submitted electronically. All insurers providing individual medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form for professional or facility services, as applicable, approved by the Federal Government and submitted electronically. An insurer may not be required to accept a claim submitted on a form other than the applicable form specified in this section and may not be required to accept a claim that is not submitted electronically, except from a health care practitioner who is exempt pursuant to Title 24, section 2985.

**Sec. D-7. 24-A MRSA §2823-B,** as amended by PL 2003, c. 218, §7, is further amended to read:

**§2823-B. Standardized claim forms**

All insurers providing group medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed health care practitioner must accept the current standardized claim form for professional services approved by the Federal Government and submitted electronically. All insurers providing group medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form for professional or facility services, as applicable, approved by the Federal Government and submitted electronically. An insurer may not be required to accept a claim submitted on a form other than the applicable form specified in this section and may not be required to accept a claim that is not submitted electronically, except from a health care practitioner who is exempt pursuant to Title 24, section 2985.

**Sec. D-8. 24-A MRSA §4235,** as amended by PL 2003, c. 218, §8, is further amended to read:

**§4235. Standardized claim forms**

All health maintenance organizations providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed health care practitioner must accept the current standardized claim form for professional services approved by the Federal Government and submitted electronically. All health maintenance organizations providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form for professional or facility services, as applicable, approved by the

Federal Government and submitted electronically. A health maintenance organization may not be required to accept a claim submitted on a form other than the applicable form specified in this section and may not be required to accept a claim that is not submitted electronically, except from a health care practitioner who is exempt pursuant to Title 24, section 2985.

**Sec. D-9. Effective date.** This Part takes effect October 16, 2003.

## PART E

**Sec. E-1. 24 MRSA §2327,** as amended by PL 2003, c. 428, Pt. E, §1, is further amended to read:

**§2327. Group rates**

A group health care contract may not be issued by a nonprofit hospital or medical service organization in this State until a copy of the group rates to be used in calculating the premium for these contracts has been filed for informational purposes with the superintendent. The filing must include the base rates and a description of any procedures to be used to adjust the base rates to reflect factors including but not limited to age, gender, health status, claims experience, group size and coverage of dependents. Notwithstanding this section, rates for group Medicare supplement, nursing home care or long-term care contracts and for certain group contracts included within the definition of "individual health plan" in Title 24-A, section 2736-C, subsection 1, paragraph C must be filed in accordance with section 2321 and rates for small group health plans as defined by Title 24-A, section 2808-B must be filed in accordance with that section.

**Sec. E-2. 24-A MRSA §423-D** is enacted to read:

**§423-D. Annual report supplement**

**1. Annual report supplement required.** Each health insurer and health maintenance organization shall file an annual report supplement on or before March 1st of each year, or within any reasonable extension of time that the superintendent for good cause may have granted on or before March 1st. The superintendent shall adopt rules regarding specifications for the annual report supplement. The annual report supplements must provide the public with general, understandable and comparable financial information relative to the in-state operations and results of authorized insurers and health maintenance organizations. Such information must include, but is not limited

to, medical claims expense, administrative expense and underwriting gain for each line segment of the market in this State in which the insurer participates. The annual report supplements must contain sufficient detail for the public to understand the components of cost incurred by authorized health insurers and health maintenance organizations as well as the annual cost trends of these carriers. The superintendent shall develop standardized definitions of each reported measure. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

**2. Exemption.** If an insurer is engaged in the type of health insurance business identified as an exception to the definition of health insurance in section 704, subsection 2 and is not engaged in health insurance in this State as defined in that section, then the insurer is not subject to the requirements of this section for the filing of annual report supplements.

**Sec. E-3. 24-A MRSA §1902,** as enacted by PL 1989, c. 846, Pt. D, §2 and affected by Pt. E, §4, is amended to read:

**§1902. License required**

A person may not act as or profess to be an administrator after August 1, 1990, unless licensed under this chapter. An administrator doing business in this State on August 1, 1990, shall apply for a license by November 1, 1990. In addition to any other penalty that may be imposed for violation of this Title, any person violating this section shall, upon conviction, be punished by a fine of not less than $100 nor more than $1,000 or by imprisonment for less than one year, or both.

An administrator licensed under this chapter on or before December 31, 2003 shall submit information by March 21, 2004 as to the types of business conducted by that administrator in this State on a form prescribed by the superintendent.

**Sec. E-4. 24-A MRSA §1903, sub-§§1 and 2,** as enacted by PL 1989, c. 846, Pt. D, §2 and affected by Pt. E, §4, are amended to read:

**1.** The names, addresses and official positions of the individuals who are responsible for the conduct of the affairs of the administrator, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation or the partners in the case of a partnership;

**2.** An application fee, as specified in section 601, that the superintendent shall apply toward the initial administrator annual fee if an administrator's license is granted to the applicant; and

**Sec. E-5. 24-A MRSA §1903, sub-§3** is enacted to read:

**3.** The specific type of business in which the 3rd-party administrator will or intends to engage.

**Sec. E-6. 24-A MRSA §1905, sub-§2,** as enacted by PL 1989, c. 846, Pt. D, §2 and affected by Pt. E, §4, is amended to read:

**2.** If the superintendent finds that the applicant is qualified for an administrator license, the superintendent shall promptly issue the license, which identifies the types of business in which the applicant may engage; otherwise the superintendent shall refuse to issue the license and promptly notify the applicant.

**Sec. E-7. 24-A MRSA §1905, sub-§5** is enacted to read:

**5.** An administrator shall submit an application to amend its license if the administrator desires to amend the types of business on its then-current license.

**Sec. E-8. 24-A MRSA §1952,** as amended by PL 2003, c. 428, Pt. H, §2, is further amended to read:

**§1952. Licensure**

A private purchasing alliance may not market, sell, offer or arrange for a package of one or more health benefit plans underwritten by one or more carriers without first being licensed by the superintendent. The superintendent shall specify by rule standards and procedures for the issuance and renewal of licenses for private purchasing alliances. A rule may require an application fee of not more than $400 and an annual license fee of not more than $100. A license may not be issued until the rulemaking required by this chapter has been undertaken and all required rules are in effect. Dirigo Health, as established in chapter 87, is exempt from the licensure requirements of this section as an independent executive agency of the State.

**Sec. E-9. 24-A MRSA §2736, sub-§3, ¶B,** as enacted by PL 1997, c. 344, §8, is amended to read:

B. The insurer must demonstrate in accordance with generally accepted actuarial principles and practices consistently applied that, as of a date no more than 210 days prior to the

filing, the ratios of benefits incurred to premiums earned for those products average no less than 80% for the previous 12-month period. For the purposes of this calculation, any savings offset payments paid pursuant to section 6913 must be treated as incurred claims.

**Sec. E-10. 24-A MRSA §2736, sub-§4, ¶C,** as enacted by PL 1997, c. 344, §8, is amended to read:

C. In any hearing conducted under this subsection, the Bureau of Insurance and any party asserting that the rates are excessive have the burden of establishing that the rates are excessive. The burden of proving that rates are adequate, not unfairly discriminatory and in compliance with the requirements of section 6913 remains with the insurer.

**Sec. E-11. 24-A MRSA §2736-A,** as repealed and replaced by PL 1979, c. 558, §8, is amended to read:

**§2736-A. Hearing**

If at any time the superintendent has reason to believe that a filing does not meet the requirements that rates not be excessive, inadequate , unfairly discriminatory or not in compliance with section 6913 or that the filing violates any of the provisions of chapter 23, the superintendent shall cause a hearing to be held.

Hearings held under this section must conform to the procedural requirements set forth in the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter 4.

**Sec. E-12. 24-A MRSA §2736-C, sub-§2, ¶F** is enacted to read:

F. A carrier that adjusts its rate shall account for the savings offset payment or any recovery in that offset payment in its experience consistent with this section and section 6913.

**Sec. E-13. 24-A MRSA §2736-C, sub-§5,** as amended by PL 2003, c. 428, Pt. H, §3, is further amended to read:

**5. Loss ratios.** For all policies and certificates issued on or after the effective date of this section, the superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for an individual health policy unless it is anticipated that the aggregate benefits estimated to be paid under all the individual health policies maintained in force by the carrier for the period for which coverage is to be provided will

return to policyholders at least 65% of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums. For the purposes of this calculation, any savings offset payments paid pursuant to section 6913 must be treated as incurred claims.

**Sec. E-14. 24-A MRSA §2808-B, sub-§2, ¶A,** as amended by PL 2003, c. 313, §1, is repealed.

**Sec. E-15. 24-A MRSA §2808-B, sub-§2, ¶G,** as enacted by PL 2003, c. 313, §2, is repealed.

**Sec. E-16. 24-A MRSA §2808-B, sub-§§2-A to 2-C** are enacted to read:

**2-A. Rate filings.** A carrier offering small group health plans shall file with the superintendent the community rates for each plan and every rate, rating formula and classification of risks and every modification of any formula or classification that it proposes to use.

A. Every filing must state the effective date of the filing. Every filing must be made not less than 60 days in advance of the stated effective date, unless the 60-day requirement is waived by the superintendent. The effective date may be suspended by the superintendent for a period of time not to exceed 30 days. In the case of a filing that meets the criteria in subsection 2-B, paragraph E, the superintendent may suspend the effective date for a longer period not to exceed 30 days from the date the carrier satisfactorily responds to any reasonable discovery requests.

B. A filing and supporting information are public records except as provided by Title 1, section 402, subsection 3 and

become part of the official record of any hearing held pursuant to subsection 2-B, paragraphs B or F.

C. Rates for small group health plans must be filed in accordance with this section and subsections 2-B and 2-C for premium rates effective on or after July 1, 2004, except that the filing of rates for small group health plans are not required to account for any savings offset payment or any recovery of that offset payment pursuant to subsection 2-B, paragraph D and section 6913 for rates effective before July 1, 2005.

**2-B. Rate review and hearings.** Except as provided in subsection 2-C, rate filings are subject to this subsection.

A. The superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for a small group health plan unless it is anticipated that the aggregate benefits estimated to be paid under all the small group health plans maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least 75% of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums. For the purposes of this calculation, any savings offset payments paid pursuant to section 6913 must be treated as incurred claims.

B. If at any time the superintendent has reason to believe that a filing does not meet the requirements that rates not be excessive, inadequate or unfairly discriminatory or that the filing violates any of the provisions of chapter 23, the superintendent shall cause a hearing to be held. Hearings held under this subsection must conform to the procedural requirements set forth in Title 5, chapter 375, subchapter 4. The superintendent shall issue an order or decision within 30 days after the close of the hearing or of any rehearing or reargument or within such other period as the superintendent for good cause may require, but not to exceed an additional 30 days. In the order or decision, the superintendent shall either approve or disapprove the rate filing. If the superintendent disapproves the rate filing, the superintendent shall establish the date on which the filing is no longer effective, specify the filing the superintendent would approve and authorize the insurer to submit a new filing in accordance with the terms of the order or decision.

C. When a filing is not accompanied by the information upon which the carrier supports the filing or the superintendent does not have sufficient information to determine whether the filing meets the requirements that rates not be excessive, inadequate, unfairly discriminatory or not in compliance with section 6913, the superintendent shall require the carrier to furnish the information upon which it supports the filing.

D. A carrier that adjusts its rate shall account for the savings offset payment or any recovery of that savings offset payment in its experience consistent with this section and section 6913.

E. Any filing of rates, rating formulas and modifications that satisfies the criteria set forth in this paragraph is subject to the provisions of paragraph F:

(1) The proposed rate for any group or subgroup does not include a unit cost change that exceeds the index of inflation multiplied by 1.5, excluding any approved rate differential based on age. For the purposes of this subparagraph, "index of inflation" means the rate of increase in medical costs for a section of the United States selected by the superintendent that includes this State for the most recent 12-month period immediately preceding the date of the filing for which data are available; and

(2) The carrier demonstrates in accordance with generally accepted actuarial principles and practices consistently applied that, as of a date no more than 210 days prior to the filing, the ratio of benefits incurred to premiums earned averages no less than 78% for the previous 36-month period.

F. Any rate hearing conducted with respect to filings that meet the criteria in paragraph E is subject to this paragraph.

(1) A person requesting a hearing shall provide the superintendent with a written statement detailing the circumstances that justify a hearing, notwithstanding the satisfaction of the criteria in paragraph E.

(2) If the superintendent decides to hold a hearing, the superintendent shall issue a written statement detailing the circumstances that justify a hearing, notwithstanding the satisfaction of the criteria in paragraph E.

(3) In any hearing conducted under this paragraph, the bureau and any party asserting that the rates are excessive have the burden of establishing that the rates are excessive. The burden of proving that rates are adequate, not unfairly discriminatory and in compliance with the requirements of section 6913 remains with the carrier.

**2-C. Optional guaranteed loss ratio.** Notwithstanding subsection 2-B, at the carrier's option, rate filings for a credible block of small group health plans may be filed in accordance with this subsection instead of subsection 2-B. Rates filed in accordance with this subsection are filed for informational purposes.

A. A block of small group health plans is considered credible if the anticipated number of member months for which the rates will be in effect is at least 1,000 or if it meets credibility standards adopted by the superintendent by rule. The rate filing must state the anticipated number of member months for which the rates will be in effect and the basis for the estimate. If the superintendent determines that the number of member months is likely to be less than 1,000 and the block does not satisfy any alternative credibility standards adopted by rule, the filing is subject to subsection 2-B.

B. On an annual schedule as determined by the superintendent, the carrier shall file a report with the superintendent showing aggregate earned premiums and incurred claims for the period the rates were in effect. Incurred claims must include claims paid to a date 6 months after the end of the annual reporting period determined by the superintendent and an estimate of unpaid claims. The report must state how the unpaid claims estimate was determined.

C. If incurred claims were less than 78% of aggregate earned premiums over a continuous 36-month period, the carrier shall refund a percentage of the premium to the current in-force policyholder. For the purposes of calculating this loss-ratio percentage, any savings offset payments paid pursuant to section 6913 must be treated as incurred claims. The excess premium is the amount of premium above that amount necessary to achieve a 78% loss ratio for all of the carrier's small group policies during the same 36-month period. The refund must be distributed to policyholders in an amount reasonably calculated to correspond to the aggregate experience of all policyholders holding policies having similar benefits. The total of all refunds must equal the excess premiums.

(1) For determination of loss-ratio percentages in 2005, actual aggregate incurred claims expenses include expenses incurred in 2005 and projected expenses for 2006 and 2007. For determination of loss-ratio percentages in 2006, actual incurred claims expenses include expenses in 2005 and 2006 and projected expenses for 2007.

(2) The superintendent may waive the requirement for refunds during the first 3 years after the effective date of this subsection.

D. The superintendent may require further support for the unpaid claims estimate and may require refunds to be recalculated if the estimate is found to be unreasonably large.

E. The superintendent may adopt rules setting forth appropriate methodologies regarding reports, refunds and credibility standards pursuant to this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

**Sec. E-17. 24-A MRSA §2839-B** is enacted to read:

**§2839-B. Large group rates**

**1. Application.** This section applies to group health insurance offered in the large group market as defined in section 2850-B, except insurance covering only accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance.

**2. Annual filing.** Every carrier offering group health insurance specified in subsection 1 shall annually file with the superintendent on or before April 30th a certification signed by a member in good standing of the American Academy of Actuaries or a successor organization that the carrier's rating methods and practices are in accordance with generally accepted actuarial principles and with the applicable actuarial standards of practice as promulgated by an actuarial standards board. The filing must also certify that the carrier has included in its experience any savings offset payments or recovery of those savings offset payments consistent with section 6913. The filing also must state the number of policyholders, certificate holders and dependents, as of the close of the preceding calendar year, enrolled in large group health insurance plans offered by the carrier. A filing and supporting information are public records except as provided by Title 1, section 402, subsection 3.

**3. Documentation.** Every carrier shall maintain at its principal place of business a complete and detailed description of its rating practices, including information and documentation that demonstrates that its rating methods and practices are in accordance with generally accepted actuarial principles and with the applicable actuarial standards of practice as promulgated by an actuarial standards board.

**Sec. E-18. 24-A MRSA §4203, sub-§3, ¶S,** as amended by PL 1997, c. 370, Pt. F, §1, is further amended to read:

S. A list of the names and addresses of all physicians and facilities with which the health maintenance organization has or will have agreements. If products are offered that pay full benefits only when providers within a subset of the contracted physicians or facilities are utilized, a list of the providers in that limited network must be included, as well as a list of the geographic areas where the products are offered. This paragraph may not be construed to prohibit a health maintenance organization from offering a health plan that includes financial provisions designed to encourage members to use designated providers in a network in accordance with section 4303, subsection 1, paragraph A.

**Sec. E-19. 24-A MRSA §4207, sub-§5,** as repealed and replaced by PL 1993, c. 645, Pt. A, §6, is amended to read:

**5.** A schedule or an amendment to a schedule of charge for enrollee health coverage for health care services may not be used by any health maintenance organization unless it complies with section 2736, 2808-B or 2839, whichever is applicable.

**Sec. E-20. 24-A MRSA §4303, sub-§1,** as amended by PL 1999, c. 742, §6, is further amended to read:

**1. Demonstration of adequate access to providers.** Except as provided in paragraph A, a carrier offering a managed care plan shall provide to its members reasonable access to health care services in accordance with standards developed by rule by the superintendent. These standards must consider the geographical and transportational problems in rural areas. All managed care plans covering residents of this State must provide reasonable access to providers consistent with the access-to-services requirements of any applicable bureau rule.

A. Upon approval of the superintendent, a carrier may offer a health plan that includes financial provisions designed to encourage members to use designated providers in a network if:

(1) The entire network meets overall access standards pursuant to Bureau of Insurance Rule Chapter 850;

(2) The health plan is consistent with product design guidelines for Bureau of Insurance Rule Chapter 750;

(3) The health plan does not include financial provisions designed to encourage members to use designate d providers of primary, preventive, maternity,

obstetrical, ancillary or emergency care services, as defined in Bureau of Insurance Rule Chapter 850;

(4) The financial provisions may apply to all of the enrollees covered under the carrier's health plan;

(5) The carrier establishes to the satisfaction of the superintendent that the financial provisions permit the provision of better quality services and the quality improvements either significantly outweigh any detrimental impact to covered persons forced to travel longer distances to access services, or the carrier has taken steps to effectively mitigate any detrimental impact associated with requiring covered persons to travel longer distances to access services. The superintendent may consult with other state entities, including the Department of Human Services, Bureau of Health and the Maine Quality Forum established in section 6951, to determine whether the carrier has met the requirements of this subparagraph. The superintendent shall provisionally adopt rules by January 1, 2004 regarding the criteria used by the superintendent to determine whether the carrier meets the quality requirements of this subparagraph and present those rules for legislative review during the Second Regular Session of the 121st Legislature; and

(6) The financial provisions may not permit travel at a distance that exceeds the standards established in Bureau of Insurance Rule Chapter 850 for mileage and travel time by 100%.

This paragraph takes effect January 1, 2004 and is repealed July 1, 2007.

**Sec. E-21. Report by Superintendent of Insurance.** The Superintendent of Insurance shall submit a report no later than January 1, 2007 to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters on any decisions by the superintendent to allow health insurance carriers to offer health plans in accordance with the Maine Revised Statutes, Title 24-A, section 4303, subsection 1, paragraph A. The report must include information on the number of enrollees covered under these plans, the financial provisions used in the plans and the designated providers that enrollees are encouraged to use under the plans, including their locations. The joint standing committee of the Legislature having jurisdiction over insurance and financial services matters may report out legislation to the First Regular Session of the 123rd Legislature to remove the repeal date of Title 24-A, section 4303, subsection 1, paragraph A.

**Sec. E-22. Report on medical malpractice awards.** The Superintendent of Insurance shall submit a report, no later than January 1, 2005, to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters regarding medical malpractice lawsuits, damage awards for noneconomic damages in those lawsuits and the cost and availability of medical malpractice insurance in this State. As part of its review, the superintendent shall consult with representatives of the medical community, legal community and medical malpractice insurance industry regarding these issues. At a minimum, the report must address the impact on the cost of malpractice insurance of a cap on noneconomic damages of $250,000 in malpractice lawsuits. The joint standing committee of the Legislature having jurisdiction over insurance and financial services matters may report out legislation to the First Regular Session of the 122nd Legislature in response to the report.

## PART F

**Sec. F-1. Voluntary limits to control growth of insurance and health care costs; report.**

**1. Voluntary restraint.** In order to control the rate of growth of costs of health care and health coverage, the Legislature asks the cooperation of health care practitioners, hospitals and health insurance carriers.

A. Each health care practitioner, as defined in the Maine Revised Statutes, Title 24, section 2502, subsection 1-A, is asked to limit the growth of net revenue of the practitioner's practice to 3% for the practitioner's fiscal year beginning July 1, 2003 and ending June 30, 2004.

B. Each hospital licensed under Title 22, chapter 405 is asked to voluntarily restrain cost increases, measured as expenses per case mix adjusted discharge, to no more than 3.5% for the hospital fiscal year beginning July 1, 2003 and ending June 30, 2004. Each hospital is asked to voluntarily hold hospital consolidated operating margins to no more than 3% for the hospital's fiscal year beginning July 1, 2003 and ending June 30, 2004.

C. Each health insurance carrier licensed in this State is asked to voluntarily limit the pricing of products it sells in this State to the level that supports no more than 3% underwriting gain less federal taxes for the carrier's fiscal year beginning July 1, 2003 and ending June 30, 2004.

**2. Report.** By January 1, 2004, the Maine Hospital Association and the Governor's Office of Health Policy and Finance shall agree on a timetable, format and methodology for the hospital association to report on hospital charges, cost efficiency and consolidated operating margins. In accordance with the agreement, the Maine Hospital Association shall report to the Governor and the joint standing committee having jurisdiction over health and human services matters.

**Sec. F-2. MaineCare report.** The Department of Human Services shall conduct a comprehensive review of reimbursement rates in the MaineCare program and shall report the results of that review to the joint standing committee of the Legislature having jurisdiction over health and human services matters by January 15, 2005. The review must provide opportunity for input from health care consumers, providers, practitioners and insurance carriers and must include consideration of the costs of providing health care in different settings, reflecting the recovery offset in bad debt and charity care, and a review of rates paid in other states and by insurance carriers and the Medicare program. The review must also identify options and costs for increasing rates and must propose strategies for achieving stated priorities. The joint standing committee having jurisdiction over health and human services matters may report out legislation on MaineCare provider rates to the First Regular Session of the 122nd Legislature.

**Sec. F-3. Commission to Study Maine's Community Hospitals.**

**1. Commission established.** The Commission to Study Maine's Community Hospitals, referred to in this section as "the commission," is established for the following purposes:

A. To study the roles of community hospitals in the 21st century, including services provided, primary care, medical centers, rural hospitals, teaching hospitals, public health, prevention and education services, relationships with other health care providers, physician recruitment, physician training, and continuing care and to evaluate those roles based on the priorities in the State Health Plan;

B. To study the economic impact of hospitals on the state and local economies;

C. To study funding mechanisms and levels, methods of reimbursement, the role of insurance and 3rd-party payors and the effect of unreimbursed care;

D. To study facility and equipment needs, financing options and capital needs;

E. To study opportunities for hospitals to cooperate through:

(1) Adopting common technologies, record sharing systems and quality control techniques;

(2) Purchasing common services, supplies and pharmaceuticals and selecting and servicing equipment;

(3) Recruiting and training staff;

(4) Managing malpractice, workers' compensation, health care and casualty risks; and

(5) Planning, designing and constructing capital improvements;

F. To explore public policy regarding community hospitals, including incentives and barriers to change, access to health care for consumers and the challenges of making transitions to new community roles;

G. To collect and evaluate data regarding statewide hospital expenditures to assess cost efficiencies, cost effectiveness and overall affordability of available health care services while preserving geographic access to care; and

H. To make recommendations regarding public policy initiatives to better define the roles of the community hospitals and to strengthen the hospitals and equip them to serve the residents of the State through the 21st century.

**2. Membership.** The commission consists of 9 members appointed by the Governor. The membership of the commission must reflect the geographic diversity of the State. The Governor shall appoint the chair from among the membership. Members serve as volunteers and without compensation or reimbursement for expenses. The membership consists of the following persons:

A. Two persons representing community hospitals chosen from a list submitted by a statewide association representing hospitals;

B. One person representing consumers of health care services;

C. Two persons representing physicians chosen from lists submitted by statewide associations representing allopathic and osteopathic physicians;

D. One person representing employers;

E. One person representing insurers or other 3rd-party payors of health care services;

F. One economist familiar with econometric modeling of health care systems and the analysis and forecasting of health care costs; and

G. One person who has expertise in public health issues.

**3. Duties.** The commission shall consider the challenges of community hospitals and must be guided by the purposes outlined in subsection 1. The commission may:

A. Hold at least 2 public hearings to collect information from individuals, hospitals, health care providers, insurers, 3rd-party payors, government-sponsored health care programs and interested organizations;

B. Consult with experts in the fields of health care and hospitals and public policy; and

C. Examine any other issues to further the purposes of the study.

**4. Staff assistance.** The Executive Department shall staff the commission through the Governor's Office of Health Policy and Finance with assistance from the State Planning Office and the Department of Human Services. The Attorney General shall provide all necessary cooperation and assistance to the commission. The commission shall work in cooperation with the Maine Hospital Association.

**5. Report.** The commission shall submit a report and any suggested legislation to the joint standing committee of the Legislature having jurisdiction over health and human services matters and the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters no later than November 1, 2004.

## PART G

**Sec. G-1. Medicare and veterans' health care.** The Governor shall engage in active negotiations with the Federal Government to increase access to federally sponsored health services for veterans in this State and to increase the rates of Medicare reimbursement for the State's health care providers.

**Sec. G-2. Task Force on Veterans' Health Services.**

**1. Task force established.** The Task Force on Veterans' Health Services, referred to in this section as "the task force," is established and consists of 13 members as follows:

A. One member of the Senate appointed by the President of the Senate;

B. One member of the House of Representatives appointed by the Speaker of the House of the Representatives;

C. Nine members appointed by the Governor:

(1) Three members who are military veterans, including one military veteran representing the Maine Veterans Coordinating Committee, one military veteran representing the Department of Defense, Veterans and Emergency Management Services, Bureau of Maine Veterans' Services and one military veteran representing the Maine Veterans' Homes;

(2) Two members representing state agencies that provide health care services; and

(3) Four members representing health care providers, including one allopathic physician, one osteopathic physician, one representative of hospitals and one provider of mental health services;

D. A representative of the federal Department of Veterans Affairs; and

E. The Director of Maine Veterans' Homes or the director's designee.

**2. Chairs.** The Senate member and the House member serve as cochairs of the task force.

**3. Appointments; convening of task force.** All appointments must be made no later than 30 days following the effective date of this Part. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. Within 15 days after appointment of all members, the chairs shall call and convene the first meeting of the task force.

**4. Duties.** The task force shall review and assess the needs of the State's veterans for health care services and the availability, accessibility and quality of public and private health care services for veterans. Based on its review and assessment, the task force shall make recommendations for the reorganization of those services to more effectively meet the needs of the State's veterans for health care services.

**5. Staff assistance.** The Department of Defense, Veterans and Emergency Management shall provide necessary staffing services to the task force.

**6. Compensation.** The legislative members of the task force are entitled to the legislative per diem, as defined in the Maine Revised Statutes, Title 3, section 2, and reimbursement for travel and other necessary expenses related to their attendance at authorized meetings of the task force. Public members not otherwise compensated by their employers or other entities that they represent are entitled to receive reimbursement of necessary expenses and, upon a demonstration of financial hardship, a per diem equal to the legislative per diem for their attendance at authorized meetings of the task force.

**7. Report.** The task force shall submit a report, no later than January 1, 2005, that includes its findings and recommendations, including suggested legislation, to the joint standing committees of the Legislature having jurisdiction over veterans affairs matters and health and human services matters

for consideration in the First Regular Session of the 122nd Legislature.

## PART H

**Sec. H-1. Transfer.** Notwithstanding any other provision of law, the State Controller shall transfer $53,000,000 from the unappropriated surplus of the General Fund to the Dirigo Health Fund in a manner to be determined in consultation with the Executive Director of Dirigo Health but in no case later than June 30, 2004.

**Sec. H-2. Appropriations and allocations.** The following appropriations and allocations are made.

**DIRIGO HEALTH**

**Dirigo Health Fund 9999**

Initiative: Allocates funds for the operating expenses of Dirigo Health, including: premium and subsidy payments under the Dirigo Health Plan, the operation of the Maine Quality Forum and administrative costs, including the establishment of the Executive Director of Dirigo Health position. Sources of funding for the fund include payments made by employers and individuals, savings offset payments and any other funds received from public or private sources.

| **Other Special Revenue Funds** | **2003-04** | **2004-05** |
|---|---|---|
| Positions - Legislative Count | (1.000) | (1.000) |
| Personal Services | $103,901 | $103,901 |
| Unallocated | 1,246,099 | 76,437,106 |
| Other Special Revenue Funds Total | $1,350,000 | $76,541,007 |

| **DIRIGO HEALTH DEPARTMENT TOTALS** | **2003-04** | **2004-05** |
|---|---|---|
| **OTHER SPECIAL REVENUE FUNDS** | **$1,350,000** | **$76,541,007** |
| **DEPARTMENT TOTAL - ALL FUNDS** | **$1,350,000** | **$76,541,007** |

**HUMAN SERVICES, DEPARTMENT OF**

**Medical Care - Payments to Providers 0147**

Initiative: Allocates funds for the expansion of MaineCare eligibility under the Dirigo Health Plan.

| **Federal Expenditures Fund** | **2003-04** | **2004-05** |
|---|---|---|
| All Other | $0 | $46,516,263 |
| Federal Expenditures Fund Total | $0 | $46,516,263 |

| **Other Special Revenue Funds** | **2003-04** | **2004-05** |
|---|---|---|
| All Other | $0 | $23,952,246 |
| Other Special Revenue Funds Total | $0 | $23,952,246 |

| **HUMAN SERVICES, DEPARTMENT OF DEPARTMENT TOTALS** | **2003-042004-05** | |
|---|---|---|
| **FEDERAL EXPENDITURES FUND** | **$0** | **$46,516,263** |
| **OTHER SPECIAL REVENUE FUNDS** | **0** | **23,952,246** |
| **DEPARTMENT TOTAL - ALL FUNDS** | **$0** | **$70,468,509** |

**PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF**

**Bureau of Insurance 0092**

Initiative: Allocates funds for one Insurance Actuarial Assistant position and one Statistician III position, for temporary employment services and for contracted consultant services to enable the bureau to meet the requirements of the Dirigo Health Act.

| **Other Special Revenue Funds** | **2003-04** | **2004-05** |
|---|---|---|
| Positions - Legislative Count | (2.000) | (2.000) |
| Personal Services | $131,265 | $133,357 |
| All Other | 514,970 | 500,000 |
| Other Special Revenue Funds Total | $646,235 | $633,357 |

| **PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF DEPARTMENT TOTALS** | **2003-042004-05** | |
|---|---|---|
| **OTHER SPECIAL REVENUE FUNDS** | **$646,235** | **$633,357** |
| **DEPARTMENT TOTAL - ALL FUNDS** | **$646,235** | **$633,357** |

**HEALTH DATA ORGANIZATION, MAINE**

**Maine Health Data Organization**

Initiative: Allocates funds for one new Epidemiologist position and the reclassification of one Comprehensive Health Planner I position to a Comprehensive Health Planner II position to enable the Maine Health Data Organization to meet the requirements of the Dirigo Health Act.

| **Other Special Revenue Funds** | **2003-04** | **2004-05** |
|---|---|---|
| Positions - Legislative Count | (1.000) | (1.000) |
| Personal Services | $64,271 | $65,119 |
| All Other | 6,250 | 0 |
| Other Special Revenue Funds Total | $70,521 | $65,119 |

| **HEALTH DATA ORGANIZATION, MAINE DEPARTMENT TOTALS** | | **2003-042004-05** |
|---|---|---|
| **OTHER SPECIAL REVENUE FUNDS** | **$70,521** | **$65,119** |
| **DEPARTMENT TOTAL - ALL FUNDS** | **$70,521** | **$65,119** |

| **SECTION TOTALS** | | **2003-042004-05** |
|---|---|---|
| **FEDERAL EXPENDITURES FUND** | **$0** | **$46,516,263** |
| **OTHER SPECIAL REVENUE FUNDS** | **2,066,756** | **101,191,729** |
| **SECTION TOTAL - ALL FUNDS** | **$2,066,756** | **$147,707,992** |

**Sec. H-3. Appropriations and allocations.** The following appropriations and allocations are made.

**HUMAN SERVICES, DEPARTMENT OF**

**Medical Care - Payments to Providers 0147**

Initiative: Appropriates and allocates funds to restore funding for the MaineCare Physician Incentive Program (PIP).

| **General Fund** | | **2003-042004-05** |
|---|---|---|
| All Other | $500,000 | $500,000 |
| General Fund Total | $500,000 | $500,000 |

| **Federal Expenditures Fund** | **2003-04** | **2004-05** |
|---|---|---|
| All Other | $973,188 | $971,021 |
| Federal Expenditures Fund Total | $973,188 | $971,021 |

| **HUMAN SERVICES, DEPARTMENT OF DEPARTMENT TOTALS** | **2003-042004-05** | |
|---|---|---|
| **GENERAL FUND** | **$500,000** | **$500,000** |
| **FEDERAL EXPENDITURES FUND** | **973,188** | **971,021** |
| **DEPARTMENT TOTAL - ALL FUNDS** | **$1,473,188** | **$1,471,021** |

See title page for effective date, unless otherwise indicated.